An overview of policies guiding health care for children

Following the recent publication of the Children’s Charter, this article examines existing legislation and guidance surrounding child health services. The author stresses that an understanding of the development of policies in this area is a prerequisite for informed nursing and health visiting practice.

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The way in which children are cared for has changed considerably over the last 125 years. The Education Act of 1870, which made education compulsory, heralded a change in status for children who, from being contributors to the family budget, became dependents. The legislation was a watershed marking the legitimacy of state intervention in parent-child relationships. Society’s attitudes towards children have not remained static; the Court report (1979) stated that: 'The rearing of the young is the fundamental issue in human society,' while the Children Act (1989) stated: 'The welfare of the child is the paramount consideration.'

THE CHILDREN ACT 1989

The Children Act received royal assent in November 1989. It is the most comprehensive piece of legislation enacted regarding children. It simplified existing legislation into a practical and consistent code. It also integrated the law relating to private individuals with the responsibilities of public authorities, in particular, social services departments, towards children, and struck a balance between family autonomy and the protection of children (Children Act 1989, DoH 1989a, Leenders 1990).

The overriding purpose of the Act was to promote and safeguard the welfare of children by:

- Recognising and defining parental responsibility
- Creating genuine partnerships between parents, local authority departments and voluntary organisations
- Recognising the need to consider racial origin, religious persuasion and cultural and linguistic background when considering a child’s welfare.

The Children Act 1989 is accompanied by regulations, subordinate legislation made by the lord chancellor or secretary of state under the authority of the Act, and documents issued as general guidance by the secretary of state. As such, it is a developing body of law; court decisions made under the Children Act 1989 become precedents for future decisions in court.

Since 1991, when the Act was implemented, there have been annual reports. The Third Children Act Report (DoH 1995a) concentrated on some of the main issues of public concern, in particular the way that local authorities are changing how they look after children by placing emphasis on supporting children in their families.

The health service shares this philosophy and every endeavour is made to give children the health care that they need at home. However, there is a need for some areas of work to be improved. In some areas the balance between child protection work and supporting the child in need must be re-examined. The families of children who are not at risk of harm or abuse may still need some help.

The Third Children Act Report (DoH 1995a) also noted that more needs to be done for children in residential care and for youngsters leaving the care of the local authority.

CHILDREN’S RIGHTS

Everyone has human rights, including children. Because they are young, however, children are more likely than adults to have their rights ignored. To protect children’s rights, the United Nations has drawn up an international agreement. This important step forward for children’s rights has been combined in one document.

The United Nations Convention on the Rights of the Child

The UN Convention on the Rights of the Child (1992), via public avowal by all signatory nations, acknowledges that children are especially vulnerable and have a right to expect special consideration. Its underlying ethos, like the Children Act 1989, is that in every situation the needs and the voice of the child must be heard and respected.

In 1991, the government agreed to be bound by the convention and in 1993 published a booklet to explain the convention to the public (DoH 1993a). A progress report on the measures adopted by the UK to give effect to the rights recognised in the convention and the progress made in the employment of...
PAEDIATRIC NURSING

these rights was made to the Committee on the Rights of the Child in 1994.

HOSPITAL CARE
Increasingly, we recognise the support that children need in order to achieve their full potential when they become adults. Those concerned with the health of children have played a major part in this understanding, and the guide, Welfare of Children and Young People in Hospital (DoH 1991a), is a distillation of the efforts and accomplishments of a wide range of experienced people, including nurses.

Welfare of Children and Young People in Hospital
Implementation of Working for Patients (DoH 1989b) enabled district health authorities to define explicitly in their contracts with provider units the standards that they require for a high quality child health service.

In 1991, the NHS Management Executive issued guidance under the cover of HSG(91)1 (NHSME 1991) The Welfare of Children and Young People in Hospital. The guide consolidates DoH guidance on the care and treatment of children in hospital, and draws on the body of good practice guidance on child care issued by other government departments, professional bodies and voluntary organisations. It helps purchasers to identify the standards they wish to secure and helps providers to achieve those standards.

The guide has five main sections:
- Contracting for hospital services
- Delivery of hospital services
- Meeting children’s special needs
- Other locally-provided services for children
- Staffing and training.

The benefits of involving parents and carers in the care of their children is a consistent theme.

THE AUDIT COMMISSION
The Audit Commission was created in 1983 and audits the accounts of local authorities and the NHS. It has produced two reports on children’s services: Children First: A Study of Hospital Services (Audit Commission 1993) and Seen But Not Heard: Co-ordinating Community Child Health and Social Services for Children (Audit Commission 1994).

Ten per cent of expenditure on hospital and community health services is on children. Although there are many well-established principles for the care of children, these are sometimes not implemented. Moreover, the effectiveness of treatments and the need for children to be in hospital is not always questioned. The report Children First (Audit Commission 1993) does not seek to rewrite the principles, but to investigate why they are not being met.

Children First: A Study of Hospital Services
Children First (Audit Commission 1993) drew largely on Welfare of Children and Young People in Hospital (DoH 1991a) guidance, identifying six main principles of care for children:
- Child and family-centred care
- Specially skilled staff
- Separate facilities
- Effective treatments
- Appropriate hospitalisation
- Strategic commissioning.

The main nursing points included:

Named nurse The Patient’s Charter national standards (DoH 1991b) included the right of every patient to have a named nurse, health visitor or midwife responsible for his or her care. The Audit Commission (1993) found that none of the wards that were visited had a policy of allocating a nurse for the duration of the child’s stay although 87 had a policy of allocating a nurse for the duration of a shift.

Nurse manager The report noted that the management team should include: ‘A senior nurse above ward sister level to provide a focus for implementing consistent policies for the care of children in all parts of the hospital.’

RSCNs Welfare of Children and Young People in Hospital (DoH 1991a) guidance set a standard of at least two qualified children’s nurses on duty 24 hours a day in all children’s departments and wards. The Audit Commission found that this standard was not being met, most wards were staffed by only one RSCN or occasionally none at night.

Paediatric community nursing The report noted that home care teams helped to reduce the time that children spent in hospital, inform parents better, support and teach parents, avoid the need for admission to hospital and provide a link between primary healthcare teams and schools. It also identified the need for more teams of RSCNs who could provide secondary care at home.

The Commission’s auditors carried out detailed local audits and reported their findings to the managers of the areas that they visited.

The study of children’s services which forms the subject of Seen But Not Heard (Audit Commission 1994) crossed the agency boundaries between community child health and social services. The report reviewed the actions agencies are taking to implement closer collaboration focusing on the individual needs of families and children.

Seen But Not Heard: Co-ordinating Community Child Health and Social Services for Children In Need
The second report (Audit Commission 1994) stressed that many activities ascribed to health and social services fall within the remit of both. Underpinning the key themes of the report are the Children Act 1989 and the NHS and Community Care Act 1990. The report stated: ‘Children under 18 make up nearly a quarter of the
The state also has responsibilities, some universal but limited to needs, such as health, and some selective such as family activities. The public health workforce should be appropriately and effectively trained if they are to carry out health education or health promotion activities.

Third, authorities and professionals are urged to work together to plan and deliver services. The report made it clear that while primary responsibility for children rests with their families, the state also has responsibilities, some universal such as health, some selective such as family support.

**Health visiting**
- Contact by health visitor after a first visit to each family with a new baby should be based on assessed needs and agreed priorities.
- Any reduction in health visiting resources should take place only after a proper assessment and evaluation of current cover.
- Health visitor activity in areas of high needs and their public health work and group work, could be organised with social services on a geographical basis.
- Organisation of health visiting should take the needs of the local population into account in order to be cost effective.

**School health**
- The functions of the school health service should be clarified, with school nurses becoming the lead professionals.
- Health commissioners must ensure that school nurses are appropriately and effectively trained if they are to carry out health education or health promotion activities.

The report made it clear that while primary responsibility for children rests with their parents, the state also has responsibilities, some universal such as health, some selective such as family support.

**CHILDREN’S SERVICES PLANS**

An order under section 17 (5) of the Children Act 1989 has been laid, and subject to Parliament’s approval, was due to come into effect on April 1 this year. The order seeks to impose a specific duty on local authorities to produce and publish children’s services plans following consultation. It is important that children’s services plans should be dynamic rather than statements of policy, focusing on desired outcomes for children and families and the communities in which they live. It is equally important that the outcomes of the plans are monitored and evaluated.

**The Allitt Inquiry**

The Allitt Inquiry (Clothier 1994) was established immediately following the trial of nurse Beverley Allitt. She was found guilty of four murders, three attempted murders, and six cases of grievous bodily harm to babies and children at Grantham and Kesteven General Hospital.

The secretary of state called for immediate action on the recommendations contained in the resulting report (NHSME 1994a). Implementation of the recommendations about nursing included definitive guidance issued by the ENB (1994) on obtaining recent references for new entrants to nursing, health screening, record of previous work patterns and screening for criminal records.

Revised occupational health guidance (NHSE 1994) dealt with procedures for health assessment in recruitment processes, student nurse selection, selection of staff for paediatric wards and follow-up of staff with a history of excessive absence through sickness.

Welfare of Children and Young People in Hospital (DoH 1991a) guidance identified staffing level standards for children’s hospital services. Districts and provider hospitals were advised to consider having at least two RSCNs (or nurses who have completed the child branch of Project 2000) on duty 24 hours a day in all hospital children’s departments and wards.

This was intended as a target for use in agreeing contractual specifications for children’s services, leaving health authorities to judge the relevance of the guidance to their local circumstances and, through contracts, to make any adaptation necessary to fit local practice or constraints caused by the facilities or resources available.

A survey (Hansard 1994) showed that these standards were met by nearly 57 per cent of hospitals during daytime shifts. However, around 40 hospitals planned to meet the standard by April 1996.

An expert advisory committee reported on alarms and clinical monitors (Medical Devices Agency 1995). Recommendations of the report emphasised policy and procedures, device management, education and best practices.
training of users, and technical issues.

The NHSE director of corporate affairs wrote to the 14 regional health authorities in England (NHSME 1994a) outlining procedures for the reporting of serious incidents, in particular, to confirm the reporting line between trusts and regional offices.

The Allitt report (Clothier 1994) concluded: 'The main lesson from our inquiry and our principle recommendation is that the Grantham disaster should serve to heighten awareness of all those caring for children of the possibility of malevolent intervention as a cause for unexplained clinical events.'

**PAEDIATRIC INTENSIVE CARE**

Paediatric intensive care has also been scrutinised (BPA 1993). The government response included commissioning a review of the report (University of York 1994). Some of the research needs identified by the reports have been incorporated into the NHS research and development programme, the results of which should allow more informed discussion about the factors that influence the survival of critically ill children. Simultaneously, the report The Neonatal Unit as a Working Environment: A Survey of Neonatal Nursing was published (Redshaw et al 1994).

**The Care of Critically Ill Children**

The British Paediatric Association (BPA) published a report of its concerns about the care of critically ill children (BPA 1993). Attention was drawn to the NHS under the cover of an executive letter (NHSME 1994b), and a copy of the report sent to every hospital with a paediatric intensive care unit. The report highlighted the need for the development of strategic plans for the care of critically ill children. District health authorities were asked to review their current level of service provision in an interim report to regional health authorities who would oversee the plans and report to the NHSME.

The report (BPA 1993) identified a shortfall of suitably qualified doctors and nurses. Subsequently, the ENB assessed the capacity and utilisation of existing children's nursing courses, including specialist paediatric nursing courses, to determine uptake and potential for expansion.

**What Way Forward for the Care of Critically Ill Children?**

The DoH asked the University of York to review the BPA report (1993) in the light of available research evidence. The university concluded that the available evidence does not allow significant statements to be made about the best way to organise staff and otherwise resource the care of critically ill children (University of York 1994).

However, the differences of opinion did not extend to the clinical or pastoral needs of very sick children and their families. The report suggested coordinated collection of standard outcome and severity data and change in the care of critically ill children to be carried out in a controlled manner which could be evaluated.

**The Neonatal Unit as a Working Environment: A Survey of Neonatal Nursing**

The NHSME recommended that links be made between paediatric intensive care and neonatal intensive care (NHSME 1994b). The survey (Redshaw et al 1994) noted that comparisons between units was difficult due to the scarcity of documented information. In addition, it was not possible to establish staffing ratios because of lack of data. The neonatal workforce is a stable workforce with a lower than average rate of sick leave despite the fact that high levels of stress were common.

**THE NHS HEALTH ADVISORY SERVICE**

The NHS Health Advisory Service exists to review and improve care in the hospital and community health services, mainly for mentally ill people and for elderly people in England and Wales, and to keep ministers informed on standards of care. It is independent of the DoH. Two recent publications concern children and young people (DoH 1994, NHS Advisory Service 1995).

**A Review of the Adolescent Forensic Psychiatry Service**

The Adolescent Forensic Psychiatry Service is provided by Salford Mental Health Services from the Grantham Unit in Salford, Manchester. The need for this specialised low volume service was confirmed by survey and found to be meeting important needs. However, the report (DoH 1994) considered that a second consultant should be employed and that work needs to be carried out on the buildings.

**Together We Stand: Child and Adolescent Mental Health Services**

This document (NHS Advisory Service 1995) reported on the current status and challenges facing mental health services for children and young people. It noted the diversity and divergence of service provision. The report commended the work of nurses in multidisciplinary teams but regretted that only a small percentage of nurses held a post-registration qualification. It stated clearly that staff working in primary healthcare teams need to be aware of child and adolescent mental health needs and urged that senior nurse managers have experience in mental health.

**THE HEALTH OF THE NATION**

The Health of the Nation White Paper (DoH 1992) identified mental health as one of the five key areas and set the target: 'To improve significantly the health
and social functioning of mentally ill people.'

The Handbook on Child and Adolescent Mental Health (DoH 1995b) provided a useful reference point for agencies setting priorities for action in developing child and adolescent mental health services.

The DoH report on specialist services (1993b) referred to team specialist child and adolescent mental health services, those services which provide secondary and tertiary care and recommended that they should be: 'Planned on a multi-agency basis; provided on a multidisciplinary basis; and seen as a fundamental part of both overall mental health services and wider children's services.'

The availability of specialist services for children and adolescents with severe, long term, or complex needs should allow other services to be targeted effectively. Equally, lack of access to specialist services will increase the pressure on other services and lead to inappropriate use of resources.

**Health of the Young Nation**

*Health of the Nation* (DoH 1992) concerned the whole population, however, placing emphasis on children and young people can bring:
- Immediate benefits to young people's health
- Avoidance of long term harm
- Long term benefits to young people's health and children of establishing a healthy lifestyle to be carried through to adult life.

With the above considerations in mind the theme for the third year of Health of the Nation was 'Health of the Young Nation'. Key issues affecting young people, including accidents, suicide and self-injury, sexual health, smoking, drugs and alcohol misuse and lack of physical activity, are its concerns.

A national conference, celebrating the third anniversary of *Health of the Nation*, brought together youth workers, teachers, parents, health promotion officers, voluntary organisations, local authorities and civil servants. In addition, there were two conferences in January and February 1995 for nurses, midwives and health visitors in recognition of their pivotal role in encouraging young people to develop lifestyles and attitudes that promote health (DOH 1995c).

**CHILDREN WITH LEARNING DISABILITIES**

One of the most vulnerable groups of children are those with learning disabilities. Disabled children benefit from early assessment of their needs and planned care strategies to minimise delay in social, language and self-help areas.

**Learning Disability Nursing Project**

The publications that resulted from the learning disability project (DoH 1995d, DoH 1995e) confirmed the valued role learning disability nurses have, in collaboration with colleagues from other disciplines, in improving the health and quality of people with a learning disability. *Learning Disability: Meeting Needs Through Targeting Skills* (DoH 1995f) emphasised the importance of viewing children as children first and learning disabled second, and that children with learning disabilities should have access to the full range of mainstream and specialist services.

**TRAINING AND EDUCATION**

All child health services should emphasise and recognise the value of early intervention, partnership with parents, use of ordinary facilities and mainstream services, planned transition into adult services, and multidisciplinary and inter-agency collaboration.

A stay in hospital can be bewildering and frightening because a child's world is the home and family. Children cannot always communicate what they are feeling or what they need, especially to strangers. Caring for them means giving each child time and attention. This is recognised by the increasing numbers of children's nurses in training. Figures released by the ENB show a steady increase in students training to nurse children.

Changes in the education of nurses to meet the healthcare needs of the 1990s and beyond have enhanced the knowledge necessary to underpin nursing practice and to enable nurses to keep up-to-date with the changes in the way we care for children. Today, Britain is a multiracial nation. Culture is derived from family tradition and relates to attitudes to health and disease. This diversity has implications for the way we plan and deliver health services for children.

**Pre-registration education**

Recognition that children are not just small adults was confirmed by the creation of Project 2000 Child Branch that continues the UK tradition of having registered sick children's nurses. Children's nurses obtain knowledge and skills complementary to the care of children, as well as a solid basis on which to build a career in children's nursing.

**Post-registration education**

The UKCC document *Standards for Post-Registration Education and Practice (PREP)* (1994) set community healthcare standards. The report proposed six areas of community practice including general nursing care of children. This formalised the increasing number of paediatric community nursing teams that have developed in response to the recognition that sick children should be nursed at home whenever possible.

**PATIENT'S CHARTER**

The Patient's Charter (DoH 1991b) set out the rights and standards that form a central part of the government's programme to improve and modernise the delivery of health surveillance to the public while continuing to re-affirm the fundamental principles of the NHS. Now children have their own charter.
Patient's Charter: Services for Children and Young People

In response to calls from children's organisations, supported by market research, A Patient's Charter: Services for Children and Young People was launched on March 20 (NHSE 1996). The charter sets standards for the delivery of children's services so that the public has some expectation of the services which should be provided (Box 1).

CONCLUSION

The examination of services for children is ongoing; the House of Commons Health Select Committee set up an inquiry in January this year. The inquiry's terms of reference include: 'The specific health needs of children and adolescents, and the extent to which those needs are adequately met by the National Health Service in all healthcare settings.' Evidence will be taken from a wide range of interested parties, including the chief nursing officer for England, Yvonne Moores.

Children's physical, emotional, social and intellectual needs must all be met if they are to enjoy life, develop their full potential and grow into participating adults. As advances are made in the range and quality of children's nursing services, it is of vital importance that nurses understand the background to the changes in the health care of children and are aware of key documents. It is hoped that this review will alert nurses, especially those who care for children at home or in hospital, to some of the most significant recent developments and that they will follow up those which are of interest to their practice in order to inform the way in which they care for children.

Box 1. Key standards set out in the Children's Charter (1996).

HEALTH VISITING STANDARDS INCLUDE:

- You can expect a visit from your health visitor — between ten to 14 days after the birth of your baby
- Within five working days if you are newly registered with a GP and have children under five years old.

SCHOOL NURSING STANDARDS INCLUDE:

- When your child starts school, you can expect to be told the name of the school nurse and how to get in contact

- You can expect your school nurse or school doctor to carry out a health check of your child during the first year of primary school.

ASTHMA STANDARD INCLUDES:

- If your child suffers from asthma, you can expect him or her to have access to inhalers at school.

PAEDIATRIC NURSING STANDARDS INCLUDE:

- Whether your child is nursed on a children's ward or adult ward, you can expect your child to have a qualified children's nurse responsible for him or her nursing care. You and your child will be told the nurse's name.

REFERENCES

NHS Executive (1994) Occupational Health Services for NHS Staff. HSG(94)/51. London, NHSE.