Child health surveillance

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What is surveillance?

Since the publication of the Court report *Fit for the Future*¹ there has been continued pressure for child health surveillance to be conducted within general practice. With the publication of the 1989 white paper *Working for Patients*² and the ensuing contract for general practitioners, child health surveillance will now be part of general medical services.

It is worth remembering that the term surveillance refers to an ongoing process that includes a number of preventive and anticipatory measures going beyond the mere quest for disease. The Department of Health statement of fees and allowances³ is not explicit about the content of child surveillance other than to state that "a practitioner who provides child health surveillance services in accordance with the programme agreed between the District Health Authority and the Family Practitioner Committee to any child under five years old registered with him or her for the purpose of child health surveillance will receive a fee to cover such services subject to him or her being admitted to and remaining on the Child Health Surveillance List." In practice, this will mean that family practitioner committees and district health authorities (England and Wales) and health boards (Scotland) will have discretion in deciding the eligibility of general practitioners to be included on the surveillance list, and current signs are that family practitioner committees and health boards are consulting with regional post-graduate education committees, district health authorities, and community paediatricians about the content of and training required for child health surveillance by general practitioners.

Organisation in general practice

It is important that practice policy should be clearly defined. The guidelines produced by Curtis-Jenkins⁴ are useful in defining such a policy (box).

Practice policy for child surveillance

- A commitment to the surveillance of children that is shared by the whole practice team
- A clear outline of what the surveillance programme will entail and who will be doing what
- A readily available up to date record of all children under 5 years in the practice
- Keeping surveillance clinics separate from the routine care of sick children. (Failing to do this will result in confusion for parents about the role and function of child health surveillance clinics)
- Continuous monitoring of performance: this can include a regular "spot check" of the practice team's target population register and review of non-attendance rates
- Regular contact between doctors, health visitors, and other practice staff involved in organising preschool examinations

Who will be responsible for surveillance?

Although the statement of fees and allowances³ relates specifically to general practitioners, any system

of child surveillance will have to be a shared exercise. Comparisons can be made with antenatal care, where general practitioners and midwives have worked well together in providing routine preventive care for patients. The contention that health visitors are less effective than doctors in detecting early signs of abnormality in children may be true only for a limited range of conditions. Although the health visitor may be in the best position, both by education and training, to note many of the potential developmental problems, it will be important that general practitioners on the child surveillance list take an active part in child care clinics and do not leave the majority of tasks to their health visitor colleagues.

Parents

If parents are to be seen as true partners in child health surveillance then they have to be well informed about clinic times, who is responsible for follow up (the doctor, the health visitor, or someone else), and they should receive the most recent version of a constantly updated leaflet about child care for under 5s in the practice. This will result in a cooperative venture between health care professionals and parents. A record card held by the parents is also in keeping with the philosophy that parents are equal partners in child care.

Examining children

The most important thing to remember when examining children is to listen to the parents—they are the best observers of their children's progress.

Although there is likely to be variation between health authorities as to the specific ages at which child health examinations will be conducted, routine pre-school surveillance usually includes a minimum of four or five examinations after the initial neonatal examination. The recent report *Health for All Children* recommended checks at birth, discharge from hospital, 6 weeks, 8 months, 21 months, 39 months, and 5 years.⁵

It is not the purpose of this paper to outline detailed developmental methods of examinations other than to highlight certain key items to be considered at different ages. In general terms the most important conditions to be excluded during physical examination are congenital dislocation of the hip, congenital heart disease, and undescended testicles in boys. More specific problems to be excluded are indicated in the box.

Surveillance at different ages: key points

6 weeks	Assess how parents are coping; check physical growth; exclude congenital dislocation of hip
8 to 10 months	Vision and hearing (distraction hearing test) are particularly important
18 to 24 months	Early language delay can be detected around this age
36 to 39 months	Hearing, language, and vision.
Preschool check	Gross motor performance, vision and fine manipulation, hearing and language

Aims of a child health surveillance programme

- To confirm normality and offer guidance on child growth and development
- To pick up variations and deviations from normal development
- To identify and follow up children with potentially handicapping conditions
- To provide opportunities for parents to discuss their children's development and health needs

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Numerous screening and growth charts exist, from the well known Denver scale to recording systems developed in Britain that incorporate ranges of normality on a visual scale.^{6,7} The handbook of preventive care for preschool children and record cards produced by the General Medical Services Committee of the BMA and the Royal College of General Practitioners provide suitable guidelines and methods of recording information on child surveillance.⁸

Identifying the target population

An accurate age-sex register is essential. Although there is an assumption that computers will solve the problems of general practice information systems, a card index system or birthday book can be perfectly adequate for the routine follow up of the under 5s. One member of the reception staff can be given the responsibility for maintaining the information system and can organise clinics, arrange follow up appointments, and keep a check on defaulters. Defaulters are often those most in need of regular review, and it will be important to identify the regular non-attenders.

Facilities and equipment

It is preferable to set aside one room specifically for examining children on the day the clinic is to be held. Toys, picture books, and paintings on the wall will provide the essential informal setting. The tests that are used for neurodevelopmental examination may vary from area to area, but it will be important for general practitioners and health visitors to understand the limitations of various screening procedures. Here again, the observations of parents will have to be taken into account when making clinical judgments.

Training and courses for general practitioners

Accreditation and eligibility for the preschool surveillance list will probably vary throughout Britain, and there is no nationally agreed system of training that will qualify general practitioners for this work. Vocational training schemes vary considerably in terms of experience in paediatrics, and six months in a hospital paediatric post does not automatically result in the trainee acquiring the skills required for routine developmental examination. Regional advisers and course organisers will have to ensure that the vocational training for general practice contains relevant experience in child care both in hospital and primary care.

Continuing education and regular updating of skills will be required for the established practitioner. Education should also include training in methods of evaluating the effectiveness of the service being provided. It will be important to take a balanced view on training and ensure that the content of courses is geared towards the practical aspects of examining children. Input from general practitioners in courses will be important; otherwise there may be a tendency for paediatricians to focus too much on the problems of handicap as opposed to normal variations in growth and development. The training of health visitors focuses specifically on child health development, and there is no doubt that health visitors will take a key role in a number of the recommended examinations.

Guidelines for the content of courses and eligibility for accreditation will be a matter for family practitioner committees and district health authorities in collaboration with regional postgraduate education committees.

Effectiveness of child surveillance

No one can tell at this stage whether a widening of the role of general practice in child care will result in

improvements in child health in the United Kingdom. For the children and their parents it will provide opportunities to reduce some of the fragmentation of care for young children. Child health surveillance will test doctors and their staff in their capacity to develop and share practice policies for the care of children.

Important points to remember in child surveillance

- Spend time in planning a shared practice policy
- Set up an effective information and record system
- Listen to the views of parents
- Ensure that there are adequate training facilities for all those involved in child care
- Review the service regularly

For the general practitioner the remuneration for child health surveillance will not be particularly high when compared with some other payments resulting from the new contract. To compensate for this, a well organised surveillance service geared to the overall needs of children and parents can lead to high immunisation rates, which will bring additional financial rewards.

Within general practice, child health surveillance is only one part of a revised contract that is still to be tested. At present, most general practitioners are probably still finding difficulty in deciding their function as advocates for children's health in the broadest sense while at the same time maintaining the more traditional job of merely being doctors to children once they become ill. Where the general practitioner is adequately trained, health visitor support is available, practice policies are agreed, and an efficient record system is in place, child health surveillance is unlikely to present insurmountable problems.

The extent to which reorganisation of child care will occur in practices will be discovered only with the passage of time. Merely drumming up customers to attend clinics is not the way forward. Clinics for routine examinations are only part of primary care for children. Within the broadest meaning of the term surveillance, opportunities are there to be grasped to develop strategies for the management of acute illness, prescribing, follow up of at risk and vulnerable groups, as well as organising examinations of children at regular intervals.

In the midst of these changes the family practitioner committees, district health authorities, and health boards will have an important function in setting up adequate methods of regular review. These methods will have to go beyond the mere collection of statistics and examination targets achieved. The time is now ripe for those charged with the responsibility of administering the new service to recognise the importance of continuous monitoring of the effectiveness of child surveillance.

- 1 Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976. (SDM Court, chairman.) (Cmnd 6680.)
- 2 Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients* London: HMSO, 1989. (Cmnd 555.)
- 3 National Health Service General Medical Services *Statement of fees and allowances payable to general medical practitioners*. London: Department of Health, 1990.
- 4 Curtis-Jenkins GH. The first five years of life. *Br Med J* 1982;285:1175-6.
- 5 Hall DMB, ed. *Health for all children*. Oxford: Oxford University Press, 1989.
- 6 Curtis-Jenkins GH. Development surveillance in general practice. *Br Med J* 1978;i:1537-40.
- 7 Barber JH, Boothman R, Stanfield JP. A new visual chart for pre-school development screening. *Health Bull (Edinb)* 1976;34:80.
- 8 British Medical Association General Medical Services Committee, Royal College of General Practitioners. *Handbook of preventive care for pre-school children*. 2nd ed. London: RCGP, 1988.