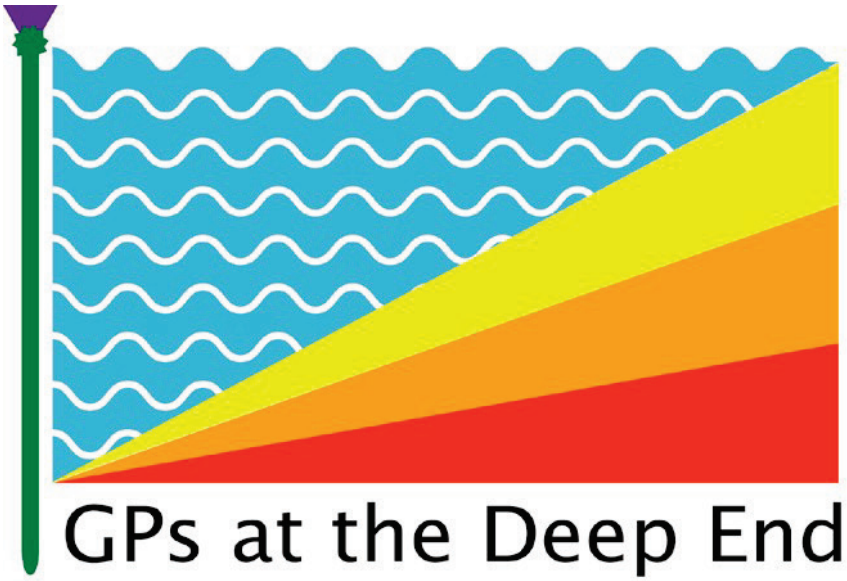

Deep End Report 23

The contribution of general practice to improving the health of vulnerable children and families

Prepared by **Dr Anne Mullin** on behalf of the steering group of the GPs at the Deep End

General practice teams have effective contact not only with large numbers of vulnerable children but also their wider families, which allied to continuity, flexibility, cumulative knowledge and trust are important resources for containing and preventing problems in the community, without recourse to emergency or specialist services. Policies to invest in the early years, to improve health and to narrow health inequalities in Scotland should acknowledge and make greater use of these relationships.

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This vignette, from *Deep End Report 20: What can NHS Scotland do to prevent and reduce health inequalities?* highlights the importance of the wider family as the context in which vulnerable children and families may need to be supported.

Preventing and reducing inequalities in health are complementary activities in general practice

David is 14 months old. His 18 year old mum Sarah has had anxiety problems since her older brother hanged himself four years ago. She started college but left when she fell pregnant shortly afterwards. Sarah does not get on well with her mother, whom she accuses of drinking and “always shouting” since her brother died. Her mum says she is “mental” and “a teenage brat”. Sarah relies heavily on her own gran Margaret. Aged 50 she has moderately severe COPD (emphysema) and continues to smoke. Margaret has had several chest infections recently and is struggling to cope with Sarah’s often strange behaviour and with a lively toddler for whom she is the main care giver.

For David the next two years, as he learns to walk, talk and interact, will have a huge effect on the rest of his life. Early years interventions such as parenting classes may be important, but on their own will fail to change his life opportunities. He will need supportive neighbours, a good nursery and adequate family income, but also optimal COPD nurse reviews, responsive alcohol and mental health services, good communication with social work, persistent contraceptive advice and smoking cessation support, to name a few. At the hub of these lies the primary care team, offering unconditional care and the possibility of trusted relationships over the span of David’s life.

This report summarises the views of General Practitioners at the Deep End in addressing the needs of vulnerable children and families, as part of efforts to invest in the early years, improve health and prevent inequalities. It draws on previous Deep End reports, the research literature, the Deep End Response to the Health and Sport Committee's consultation on health inequalities and the early years and proposals for integrated care for the population served by Govan Health Centre.

SUMMARY

- Inequality and poverty in early childhood have long term consequences that affect the entire life course.
- Interventions in early childhood provide the foundations of good health and reduce the scale of disease and premature death in later life.
- GPs at the Deep End recognise the magnitude of the challenges in addressing inequalities in early years and have outlined the intrinsic strengths of general practice in contributing to this challenge.
- General practices' contacts with the wider family, in good times and bad, allied to continuity, flexibility, cumulative knowledge and trust, provides an important resource and basis for sustained preventive efforts, linking with other services and community resources.
- Current policies such as GIRFEC (Getting It Right For Every Child) make virtually no reference to this important role of general practice teams.
- The key professional relationship between health visitors and GPs is undermined by the disproportionate numbers of vulnerable children on health visitor caseloads in very deprived areas, and the gaps that arise as a result of difficulties in health visitor recruitment.
- General practices can lead in developing strong local systems, based on multiple relationships between services, to contain and prevent problems without recourse to emergency services.
- This requires a fundamental policy shift that recognises the "Inverse Care Law" which continues to limit what practitioners in the front line are able to offer, in terms of a proportionate response to the needs of vulnerable families.
- The high political priority given to policies supporting the health of families with young children should be evaluated in terms of their impact on health inequalities in the early years and beyond.
- The Govan Integrated Care Project is a pragmatic approach to develop and evaluate a robust intervention to support vulnerable children and families at an early stage.

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"General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.*

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INTRODUCTION

This paper comments on current policies, from the perspective of General Practitioners at the Deep End, who work in Scotland's 100 most deprived communities. It describes the contribution that general practice could make to the local implementation of early years policies and current barriers, including the inverse care law and inconsistent working practices between agencies. Finally, we comment on specific questions posed by the Health and Sport Committee of the Scottish parliament for its review of health inequalities in the early years.

POLICY CONTEXT

At the passing of the Children and Young Persons (Scotland) Act 1932, Cowan commented:

> *'It has well been said that the civilisation of any nation may be summed up by the treatment meted out to its youth...The increasing value set upon childhood and youth is a study in the evolution of the human conscience'* (1933, Introduction).

There are periods of time that mark a progression in our society's approach to child welfare. General Practitioners at the Deep End welcome the Government's current initiative and the opportunity to consider issues of child wellbeing and safeguarding in the most deprived practices in Scotland. We also welcome this chance to contribute written evidence for the consideration of the Health and Sport Committee.

General Practitioners at the Deep End believe that it is imperative that Scotland's Government continues to address inequities in health across the range of social dimensions that it has outlined in its current early years framework. We fully support the Scottish Government's adoption of an explicit quality and fairness agenda for its early years policies.

We concur with current thinking that 'Health inequalities are an emergent effect of political decisions, and the collective processes and actions within societies which shape those decisions' (McCartney et al 2013, p.225) and have tried to address these concerns within The Deep End manifesto (Deep End Report 20). A section is devoted to the contribution that general practice makes to issues of child welfare and wellbeing, recognising both the rights of the child and the need to work flexibly and proportionately with vulnerable children and their families in their early years and beyond (Deep End Report 12).

In particular it is often clear, from our experience of vulnerable children and families how broader, politically-determined, social inequalities contribute to health inequalities (Norheim et al, 2009) and are reflected in the daily working practices of primary care. GPs are well placed to understand the specific challenges that result in the vulnerable family and the vulnerable child (Hertzman & Bertrand, 2007) and have an important role to play in contributing to the mitigation and reduction of inequities in health (Popay et al, 2007).

GIVING GENERAL PRACTICE ITS PLACE

There is still work to be done in developing the role of GPs in early years development (Lykke & Reventlow, 2013). General practice has intrinsic strengths (contact, coverage, continuity, flexibility, cumulative knowledge and trust) which are possessed by few other public services. In particular, GPs' contact with the wider family, in good times and bad, provide a sound basis for sustained preventive efforts, linking with other services and community resources. These strengths are largely ignored, however, for example in GIRFEC (Getting it Right For Every Child), which barely mentions general practice as a resource for child health. When policy is developed with no explicit role for GPs, service provision is diminished with inconsistent outcomes for vulnerable children.

THE EARLY YEARS: INCREASING THE IMPACT OF GENERAL PRACTICE

Optimising the role of the primary care team in the early years requires a strong welfare state with broadly supported policies, politically enabled via redistributive taxes and transferring policies from national to municipal levels, to achieve population-wide outcomes (Dorling, 2013).

General Practitioners at the Deep End aspire to contribute to the growing body of empirical evidence of the importance of maximising early years experiences through the development of the Govan Integrated Care Project.

THE GOVAN INTEGRATED CARE PROJECT

General Practitioners at the Deep End have outlined a project that is being considered for funding by Scottish Government. We think that this approach answers many of the challenges of addressing inequalities in early years:

- Building around the continuity of contact which general practices have with the whole family, in bad times (when crises have to be solved) and good times (when preventive efforts are possible).
- Improved links with social work, health visiting and child services.
- Addressing the inverse care law with additional consulting time, and support for regular multidisciplinary meetings.
- Improved links to community resources for health, via the Link Workers project.
- An enhanced leadership role for general practices, in partnership with each other, social work and the CHCP.

- A commitment to shared learning and the production of evidence with which to evaluate integrated care.
- The potential to generate robust 'epidemiologically sensitive' data to aid analysis of indicators of child well-being.

SPECIFIC QUESTIONS

How effective are early years interventions in addressing health inequalities?

There is a plethora of evidence on the contribution of early years intervention (Hertzman et al, 2010) to optimal child development and to ameliorate the effects of inequities in health that are cumulative over the life course as a consequence of a combination of biological insults and psychosocial factors (Kroenke, 2008). It is uncontested that cumulative adverse child experiences mediated through increased psychosocial stress have long-term negative effects on the lifespan of adult health and social status (Appleton et al, 2012, Kelly-Irving et al, 2013). Early adverse experiences can shape health across an individual's lifetime and potentially across generations (Braveman & Barclay, 2009). Whilst it is recognised there have been improvements in this agenda throughout Europe, child health inequalities in the UK are worse than ever (National Children's Bureau, 2013).

With compelling evidence of increasing inequalities, ensuring a healthier life for children, by developing and supporting work directed at vulnerable children living in risky environments, is especially necessary. The broader family environment is relevant to Deep End GPs who are familiar with the broader aspects of “children in need”, such as those living with financial disadvantage in family situations dominated by, for example, parental mental health and addiction issues (Turney, 2011).

According to the World Health Organisation (WH0, 2003) preventative health services for mothers and children and improving knowledge amongst parents and children through health and education programmes can reduce risk factors of vulnerability. General Practitioners at the Deep End have endeavoured to encapsulate many of the requirements of such strategies to improve early child health and beyond, by recognising the vulnerable child within the family setting.

The Govan Integrated Care Project outlines a whole systems approach which anticipates ongoing child needs and a translation of high policy goals into pragmatic working practices within a model of integration of professional expertise with reliable systems of data capture and analysis. The project capitalises on general practice as the natural hub of local health systems. It promotes a child-centred holistic approach to improve outcomes for vulnerable children and families. The project maximises available resources by working closely with social work colleagues amongst others to improve child health, reduce suffering and promote resilience in vulnerable children across all age groups to develop a system that can adapt and be responsive to evolving child needs.

What are your views on current early years policy in Scotland in terms of addressing health inequalities?

General Practitioners at the Deep End support the philosophical underpinning and strategic direction of 'The Early Years Framework', 'Equally Well' and 'Achieving our Potential' to promote social sustainability and reduce health inequalities. Their key messages are reflected in the Deep End's positional statements on working with vulnerable children and families within a framework of integrated working (Deep End Reports 12 and 18). The emphasis on universal services fully contributing to improving outcomes for children by promoting integration of services that are child-centred is vital if we are to move away from reactive crisis management to pro-active prevention of adverse outcomes (Holmes & McDermid, 2013; Melton, 2012). We also concur that partnership working with parents is vital to improve communication and engagement in areas of clinical need (Stille et al, 2013).

There are a number of obstacles that stand in the way of GPs at the Deep End fully engaging with these strategies. The Scottish Government (2011) has stated that a priority for action is that 'Universal services are strengthened to improve identification and intervention to better meet the needs of vulnerable children and families'. This implies that GPs (as universal health care providers) would be fully cognisant of this policy directive. It remains an elusive aspiration at present for general practice because there is little attention given to the complexity of delivering holistic child health in the current GMS (2013) contract. It is worrying that there is reduced opportunity in general practice to have contact with children and families through structured child health screening which has resulted in less attention being paid to vulnerable children (Wood & Wilson, 2012).

The Government recognises that 'action at a local level' (Scottish Government,) is vital to enact the implementation of a national policy but it is clear to GPs at the Deep End that more work is needed to make this possible.

What role can the health service play in addressing health inequalities through interventions in the early years?

> *'The intrinsic strengths of the system of general practice within NHS Scotland are patient contact, population coverage, continuity, flexibility, cumulative knowledge, long term relationships and trust. The system of complete and non-overlapping patient registration provides the only basis for NHS Scotland to assess progress in providing care for 100% of the population' (Deep End Report 20).*

The social determinants of health have increasingly received international attention since the World Health Organisation's publication on this topic in 2008 (WHO). Health care and specifically general practice should be fully functional within a robust primary care health system to improve the wellbeing of vulnerable children and their families (Klevens & Whitaker, 2007; Scribano 2010) to reduce social inequalities in health.

We value health visitors as the profession with whom GPs work most closely when holistically addressing the unmet needs of vulnerable younger patients. This professional relationship is undermined, however, by disproportionate numbers of vulnerable children in individual Health Visitor's caseloads and the gaps that arise as result of difficulties in recruitment (Appleton, 1996, 2011).

This is a specific example of the inverse care law in Scotland, whereby the availability of good medical care tends to vary inversely with the need for it in the population

served. Universal coverage on its own is not enough. Services must also be able to respond proportionately to the problems that families present and we must be mindful that general practice as a material resource is a potentially important social determinant of health and health inequalities that can widen inequalities if it is inequitably distributed (Furler,2006). We understand as working professionals within a service that has ever increasing demands placed upon it that wellness in young children is related to many factors (Frank et al, 2010). Such factors are often out with the remit of general practice for example food and housing security (Chilton et al, 2013) but because of the association with childhood trauma they remain relevant to the function of general practitioners as family doctors supporting the health and wellbeing of our youngest patients.

Childhood poverty rates in Scotland are a major concern to GPs at the Deep End, particularly because of the current cuts to the welfare budget. We know that there is a clear association between disadvantage with social class and adverse effects on child health in the first 10 years of life (Petrou et al, 2006) with increased mortality rates (Collison et al, 2007) – the 'toxic effects' of poverty on child health (McNeill, 2010).

Childhood poverty is a potent predictor of poor adult health outcomes particularly for cardiovascular disease and diabetes. Such negative outcomes are not necessarily modified by improved circumstances in later life (Dennis, 2011).

In early childhood, growth patterns (Musicco, 2011), increased respiratory disease (Watts¸ 2012) and obesity rates (Townsend et al, 2012) are all quantifiable measurements of health inequalities but these need to be aligned with other epidemiologically sensitive indicators which better contribute to the definition of well-being in its fullest sense.

General Practitioners at the Deep End suggest that general practice could more actively be involved at a local level in determining many of the qualitative indicators of child well-being. Current data do not encompass the holistic work that GPs undertake in supporting the vulnerable child. Data are epidemiologically insensitive and do not reflect the 'cumulative exposures' that economically disadvantaged children experience (Frank & Haw, 2011). They are trawled from proxy indicators that give a reductionist and restricted account of the work that GPs undertake alongside their primary care team colleagues (Woodman et al, 2012).

Combining a targeted approach to social the determinants of health, such as the reduction of family and child poverty, with an approach to universal child health services, which is equipped to address the inverse care law, is at the centre of Deep End commentary on child health provision and the role of general practice in reducing heath inequalities (Deep End Report 12).

The complex interplay of low socioeconomic status and socio-cultural context of specific situations requires a different approach to understanding health's contribution to reducing childhood vulnerability and promoting resilience in early childhood that is sustainable across the life course. Political commitment to preventive spend is key (Davies et al, 2013), but what is also required “downstream” is the strategic support of child health professionals and their partners to work together with common cause (Hernandez et al, 2010) to ameliorate the impact of adverse early years experiences.

We have outlined in the Govan Integrated Care Project how inequity may be addressed through collaborative working at a community level and across professions to improve outcomes for vulnerable children in their early years and beyond.

What barriers and challenges do early years services face when working to reduce health inequalities?

General Practitioners at the Deep End have described the challenges to tackling health inequalities in several of their publications. One of the biggest barriers to working holistically with vulnerable children in Deep End practices is the flat lining of resource within the primary care team when there are clear gradients of need with children with long- term conditions between the most and least deprived quintiles (Rahman et al, 2014). This needs to be addressed because children in areas of low socioeconomic status consult more frequently. This contact can be the basis of improving access to other support services and addressing unmet needs beyond immediate physical health symptoms (Maharaj et al, 2014).

The time required to develop local knowledge and professional discretion to allow GPs to contribute to the jigsaw approach of early intervention strategies and to tackle inequities in health is constantly eroded by other contractual requirements.

GPs tend to work intuitively often using tacit knowledge when recognising children with unmet needs (Holge-Hazelton & Tulinius, 2010). In this respect technocratic knowledge that delineates professional practice lags behind the sum of knowledge that we possess and fails to acknowledge the verbal encounters between professionals that contribute to the process of understanding vulnerability in early years (Saario et al, 2011).

Are there any specific initiatives or research evidence from Scotland, UK or internationally that you would wish to highlight to the Health and Sport Committee?

Examination of Scandinavian models of child welfare policy show that these countries are leading the way in the development of integrated and adequately funded services to reduce the impact of the social and cultural determinants of adverse health outcomes(Tallarek et al, 2013; Willumsen, 2008; Wolfe et al, 2013).

It is a research challenge to capture and evaluate the complex relationships that are built up in the community setting (Guterman et al, 2013) and to demonstrate positive outcomes for vulnerable children using targeted services (Brannstrom et al, 2013). General Practitioners at the Deep End understand that children can move seamlessly between categories of 'in need' and 'at risk of harm' depending on the chronicity and severity of stressors within the family setting. There is concern that a child health system that uses definitional categories of need to determine access to limited services, risks having those children with greater unmet needs wrongly assigned to a core category of service (Wood et al, 2013).

It is difficult to exclude the human factor from our professional and societal understanding of the complex pathways by which low socioeconomic status mediates vulnerability in early childhood, when 'developmentally vulnerable' children are found in all social groups (Woolfson et al, 2013). At the core of assessing the status of the child within complex family dynamics is the requirement of direct family contact (Wilson et al, 2013) and within the current early years health framework this needs a fully developed GP 'hub' with attached health visitor support.

It is easy to underestimate the importance of universal coverage of the non-stigmatising robust child health service that general practice and general health visiting provide in early childhood. General Practitioners at the Deep End welcome the development of cost-effective parenting programs (O'Neill et al, 2013) but urge caution

in adopting targeted services without fully resourcing universal health care systems. Whilst targeted approaches can be effective in selected populations, they do not prevent the majority of adverse outcomes for children (Browne & Jackson, 2013).

NOT GETTING OFF THE HOOK: MOVING FROM RHETORIC TO REALITY

General Practitioners at the Deep End have developed a clear understanding of their role in mitigating and reducing health inequalities. The importance of advocacy (Melton, 2013) that is developed within a long-term trusting one-to-one relationship (Cupples et al, 2011) and establishing clear communication channels (Gallagher et al, 2011) to address the anxieties and fears of vulnerable families who experience multiple stressors is outlined in an action participation research framework within the Govan Integrated Care Project.

This approach is intended to remove many of the barriers to accessing services and to improve outcomes for vulnerable children in their early years and beyond. This may be realised as linking families into voluntary sector agencies, structured parenting support groups (Furlong et al, 2013) or referral to statutory agencies with the GP and primary care team as the common reference point for services. It is possible to achieve this because general practice has universal population reach and observes much higher rates of children living with unmet needs (Denholm et al, 2013) than reflected in official child welfare statistics (Pinto & Maia, 2013). It is acknowledged that non stigmatising holistic support for vulnerable children in their early years is possible with increased parental engagement if the service is regarded as a function of universal health provision (Attree, 2005).

General Practitioners at the Deep End recognise that working in partnership with Scottish Government to successfully implement policies is vital if we are to make any meaningful difference to health inequalities in our youngest patients and to avoid the 'paradox of rhetorical commitments to tackling health inequalities' (McCartney et al , 2013 p.225) by enacting policies that propagate them.

The Inverse Care Law remains a substantial obstacle to realising the benefits of a universal service to improve outcomes and reduce health inequities in our youngest patients that will have long-term benefits into adolescence across a range of social dimensions (Richter et al, 2012).

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