Levelling Up. Providing Equitable GP Healthcare to Children and Young people in Deep End Practices

What are Health Inequities?

- **Equality = SAMENESS**
  - Only works if everyone starts from the same place

- **Equity = FAIRNESS**
  - Making sure people get access to the same opportunities
'In a country where the income and wealth gaps have become greater than at any point in living memory, and which are greater than in almost all other similar wealthy countries, you should expect very high and rising levels of crime, social disorder, dysfunction, rising polarisation, fear and anxiety.'

http://www.dannydorling.org/?page_id=3008

‘Young adults in both Britain and the USA today have only ever known a country in which income and wealth have been redistributed from poor to rich—to the detriment of all. How much money could be saved by doing the reverse and redistributing from rich to poor?’

http://www.dannydorling.org/?page_id=3008

Our analysis demonstrates that persons who suffer housing arrears experience increased risk of worsening self-reported health, especially among those who rent. Future research is needed to understand the role of alternative housing support systems and available strategies for preventing the health consequences of housing insecurity... These adverse associations were only evident in persons below the 75th percentile of disposable income


Anne Mullin  November 2017
<table>
<thead>
<tr>
<th>Measure</th>
<th>Govan/ Linthouse</th>
<th>White Craigs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Life Expectancy</td>
<td>67</td>
<td>85</td>
</tr>
<tr>
<td>Female Life Expectancy</td>
<td>73</td>
<td>94</td>
</tr>
<tr>
<td>Patients hospitalised with coronary heart disease</td>
<td>570</td>
<td>35</td>
</tr>
<tr>
<td>Early deaths from CHD (&lt;75)</td>
<td>95</td>
<td>35</td>
</tr>
<tr>
<td>Patients hospitalised with asthma</td>
<td>94</td>
<td>44</td>
</tr>
<tr>
<td>Patients with emergency hospitalisations</td>
<td>11880</td>
<td>5621</td>
</tr>
<tr>
<td>Patients (65+) with multiple emergency hospitalisations</td>
<td>8913</td>
<td>3979</td>
</tr>
<tr>
<td>Patients with a psychiatric hospitalisation</td>
<td>630</td>
<td>95</td>
</tr>
<tr>
<td>Deaths from suicide</td>
<td>36</td>
<td>11</td>
</tr>
<tr>
<td>Teenage pregnancies</td>
<td>81</td>
<td>17</td>
</tr>
<tr>
<td>Mothers smoking during pregnancy</td>
<td>32%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Immunisation uptake at 24 months - 5 in 1</td>
<td>97.6%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Immunisation uptake at 24 months - MMR</td>
<td>97%</td>
<td>93%</td>
</tr>
<tr>
<td>Children Living in Poverty</td>
<td>38%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Child Health- What’s It Got to Do With General Practice?

Health Promotion   Supporting Parenting   Child and Youth Friendly Services   Transitional Care   Safeguarding   Managing Sick Children   End of Life Care   Disability and Complex Needs   Mental Health   Medicines and Prescribing

‘The RCGP firmly believes that general practice occupies a central position in children and young people’s health, particularly in the diagnosis and management of illness and the promotion of health and wellbeing. We are concerned that unless the profession acts now to protect this important and trusted role, it will become eroded and lead to serious fragmentation of care for this vulnerable group of patients’

(RCGP Child Health Strategy 2010-2015)
‘The intrinsic features of general practice in the NHS, including an unconditional approach in clinical encounters, flexibility, population coverage and long term continuity, are hugely important for the provision of equitable and efficient health care, with a proven record of earning patient’s trust, but needing closer links with specialist services (including specialist services in the community such as mental health, alcohol and drugs misuses, child health etc) and community resources’

Deep End Report 32
Enduring Challenges

‘Despite the improving picture of childhood health, there remains significant inequality in children’s experience of the wider social determinants of health, resulting in long term and enduring health inequalities... health is influenced by the distribution of income, wealth and power within a society which are in turn influenced by the social, economic and political structures...

This means that children living in poverty are most at risk of the negative impact of the wider determinants of health. One in four (260,000) of Scotland’s children are officially recognised as living in poverty – defined as living in a household with less than 60% of median household income’

http://www.healthscotland.scot/population-groups/children

Anne Mullin, November 2017
Progress – It’s taking a long time

There have been over 400 different initiatives, strategies, funding streams, legislative acts and structural changes to services affecting children and young people over the past 21 years. This is equivalent to over 20 different changes faced by children’s services for every year since 1987.

Since 1987, there have been 98 separate Acts of Parliament affecting children across the UK. This is equivalent to over four every year for the past 21 years.

The Scottish Government should publish and implement the Child and Adolescent Health and Wellbeing Strategy ‘a clear accountability framework setting out responsibilities for professionals, the public and civil society as well as details about resources and funding to implement it’

Reduce the number of child deaths (each year between 350 and 450 infants, children and young people die in Scotland)

Develop integrated health and care statistics

Develop research capacity to drive improvements in children’s health

Reduce child poverty and inequality

Maximise women’s health before, during and after pregnancy

Introduce statutory sex and relationships education at all schools

Strengthen tobacco control

Tackle childhood obesity effectively

Maximise mental health and wellbeing throughout childhood

Tailor the health system to meet the needs of children, young people, their parents and carers ‘a joined-up approach by health and other agencies’

Implementing guidance and standards

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The Demise of Preventative Child Health Care in General Practice

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Percentage of NHS expenditure on community health and general practice (right axis) vs the number of emergency admissions (left axis) in **Scotland** by year, 2001/2-2015/16. Source: ISD Scotland.

- **Number of emergency adms**
- **% spent on CH**
- **% spent on GP**

**2004 GP Contract**

INVISIBLE CHILDREN LEARNING FROM SIGNIFICANT CASE REVIEWS – WHAT LIES BENEATH

• RESISTANT PARENTS - HOSTILITY – WORKERS BACK OFF AVOIDANT PARENTS - DNAS FOR MEDICAL OR SCHOOL APPOINTMENTS - CHAOTIC/UNSTABLE PARENT
• APPARENT COMPLIANCE - NOT IN FOR HOME VISIT, BUT COME TO OFFICE LATER – DIRT ETC COVERING BRUISES, CHILD NOT SEEN ALONE - COLLUSION BY WORKERS
• CHILD NOT SEEN - NON SCHOOL ATTENDER
• CORE FAMILIES ON HEALTH VISITOR CASELOADS – NO REGULAR CONTACT
• CULTURAL – DIFFERENT VIEWS ABOUT CHILD REARING
• TRAFFICKING
• ORGANISATIONAL - BIG CASELOADS - POOR RECORDING - INEXPERIENCED WORKERS, LACKING CONFIDENCE - WORKER THRESHOLDS - LINKING TOGETHER INFORMATION E.G. INVOLVING THIRD SECTOR

= INVERSE CARE LAW (HEALTH)
= INVERSE INTERVENTION LAW, START AGAIN SYNDROME (SOCIAL SERVICES)

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I noted such cases of children without an ounce of superfluous flesh upon them, with skin harsh and rough…I fear it is from this class that the ranks of pilferers and sneak thieves come, and their cleverness is not of any real intellectual value’

Dr Arkle reporting to the Poor Law Commission in 1908

Anne Mullin  November 2017
Young people...suffered social injustice from the politics of distribution (of resources) but also they face injustice in respect of the politics of recognition; that is, their circumstances are misrecognised and presented as a consequence of their own flaws and failings. This can be seen with what is one of the dominant tropes of British politicians, policy makers, think tanks, and welfare practitioners: those who are not successful in their transitions from school to employment are deficient, with the most fashionable ‘lack’ currently being of aspiration (‘grit’, ‘resilience’, ‘character’, ‘social capital’, ‘skills’, ‘qualifications’ and ‘experience’ are also regularly cited as the things young people are lacking). Elsewhere I have described this as voodoo sociology...
**HORIZON 1**

- **Sinking in The Deep End**
  - Pre-established team working but no strategic support
  - Collective memory of working with attached social worker - a positive experience
  - Clunky communication systems - an ongoing frustration
  - Fragmented data systems
  - GP contract - minimises maternity, paediatric and family health care
  - Thresholds, exclusion criteria - Inverse Care Law
  - No specific role for GPs in the care of vulnerable children and families despite being the ‘hub’ and point of contact for other services/ outside agencies.
  - Very little research to argue our case
  - Experience doesn’t seem to count

**HORIZON 3**

- **Protected time- case planning**
- **Professional relationships- face-to face discussions- we are all generalists now**
- **Infrastructure- e.g. MDT meetings, whole systems approach, 1y & 2y care interface, steering group**
- **Multimorbidity database ‘KIS for Kids’**
- **Documentation-minuted meetings ,diaries ADMIN SUPPORT**
- **Patient engagement**
- **Knowledge dissemination- nationally, internationally**
- **Research that fits working practices (e.g.Evaluation Report)**
- **The bigger picture-Links Workers,JSTs Mental Health, Education, 3rd Sector**
- **Normalising the project work through connectivity, embedded knowledge, knowledge exchange – Scaling up an ecology of learning**
Govan SHIP - MDT

Social Care Worker

Mental Health

District Nurse

Health Visitor

Rehabilitation

Links Worker

FOCUS Patient / Client PERSON

General Practitioner (GP)

As Required

Hospital Sector
- Housing
- Carer Support
- Welfare
- Well being
- Social isolation

Anne Mullin  November 2017
## A Sense of Perspective

<table>
<thead>
<tr>
<th>SHIP Practice Patients &lt;18Y</th>
<th>ALL</th>
<th>SHIP</th>
<th>Non-SHIP</th>
<th>SHIP (as %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>1209</td>
<td>129</td>
<td>1080</td>
<td>10.7%</td>
</tr>
<tr>
<td>Male</td>
<td>1322</td>
<td>153</td>
<td>1169</td>
<td>11.6%</td>
</tr>
<tr>
<td>Total</td>
<td>2531</td>
<td>282</td>
<td>2249</td>
<td>11.2%</td>
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</table>

<table>
<thead>
<tr>
<th>G51 SW CP Stats Children&lt;18Y</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked after away from home</td>
<td>N=61</td>
</tr>
<tr>
<td>Looked after at home</td>
<td>N=63</td>
</tr>
<tr>
<td>Placed on CP Register</td>
<td>N=15</td>
</tr>
</tbody>
</table>
'I have considered the benefits of establishing a national database on children...I was told that such a database is technically feasible...that every new contact with a child by a member of staff from any of the key services would initiate an entry that would build up a picture of the child’s health, developmental and educational needs’ Laming 2003

http://lx.iriss.org.uk/content/victoria-climbie-inquiry-summary-and-recommendations

Anne Mullin  November 2017
THE EXPERIENCE OF A GOOD ENOUGH CHILDHOOD - IS IT JUST TOSSING A COIN?

Vulnerability

Resilience
‘...it is still premature to start widespread screening for adverse childhood experiences (ACE) in health care settings until we have answers to several important questions: 
1) what are the effective interventions and responses we need to have in place to offer to those with positive ACE screening,
2) 2) what are the potential negative outcomes and costs to screening that need to be buffered in any effective screening regime
3) what exactly should we be screening for?’

Resilience- What Exactly Is it?

- Considered within the domains of positive family relationships, emotional expressiveness (e.g. self esteem), family embeddedness in the community, peer relationships, sexuality

- At a population level the great diversity of risk-factor combinations and their very small prevalence make the tasks of identifying vulnerable patients and defining eligibility for support very difficult for policy-makers - this is where the SHIP project matters

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‘Extended surgery consultation with school age child and mother due to behavioural problems at school stemming from Autistic Spectrum Disorder. Outcome: discussed support structures available through health, education and third sectors. Information regarding diagnosis and impact on family discussed at length. Management strategies discussed and agreed for both individuals with goal setting, etc.’

‘Child < 5 years frequent attender to surgery with minor self-limiting symptoms. English poor and requires translator. Planned review to discuss support and education of such illness; Outcome: linked in with Health Visitor for further ongoing support which also involves local third sector agencies. Aim to support mother and reduce attendances at general practice.’
An Ecology Of Learning- Scaling Up

• Three inter-related aspirations- sustaining core general practice, delivering extended services, leading a population health system
• Larger scale has the potential to sustain general practice through operational efficiency and standardised processes, maximising income, strengthening the workforce and deploying technology.
• Scaling up will take a lot of hard work ... All GPs will need to play a part in making these new organisations successful
• The evidence that these organisations can improve quality is mixed. Patients had differing views about the benefits of large-scale organisations. Some appreciated increased access, while others were concerned about losing the close relationship with their trusted GP
• Policy-makers and practitioners should be realistic in their expectations of the pace at which large-scale organisations can contribute to service transformation.

https://www.nuffieldtrust.org.uk/research/is-bigger-better-lessons-for-large-scale-general-practice

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SCANNING THE GENERALIST’S 3RD HORIZON

Improving health in deprived areas and narrowing health inequalities

Keeping patients in the community and relieving pressure on emergency services

Coordinating care for patients with multiple problems, reducing fragmentation of care and driving integrated care, based on patients’ needs.

CONSTRUCTING THE GENERALIST’S 3RD HORIZON

Building strong patient narratives, based on knowledge and confidence in managing their problems and accessing available resources and services

Building strong local health systems, based on general practice hubs and clusters linked to other local resources and services

Building a strong generalist function within the NHS, based on networks of local systems serving similar types of populations, with shared learning to ensure that “the best anywhere becomes the standard everywhere”.

(Deep End Report 32)

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SPACE AND TIME FOR INTEGRATED WORKING - THE FINAL FRONTIER

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