• To encourage recognition of young children as social actors from the beginning of life, with particular interests, capacities and vulnerabilities, and of requirements for protection, guidance and support in the exercise of their rights;

• To emphasize the vulnerability of young children to poverty, discrimination, family breakdown and multiple other adversities that violate their rights and undermine their well-being;

• To contribute to the realization of rights for all young children through formulation and promotion of comprehensive policies, laws, programmes, practices, professional training and research specifically focused on rights in early childhood.

CHILDREN’S HUMAN RIGHTS ARE BEING INCREASINGLY EMBEDDED INTO EU LEGISLATION AND POLICY. THIS IS HELPING TO ENSURE THAT CHILDREN’S HUMAN RIGHTS ARE PROTECTED, RESPECTED AND FULFILLED ACROSS THE EU IN LINE WITH THE CHARTER OF FUNDAMENTAL RIGHTS.
The State Discovers Child Welfare - History Matters

• The 19th century was regarded as an important period of welfare reform whose philosophical approach changed from ‘rescue, reclamation and reform of children’ to the involvement of children given a new social and political identity as belonging to ‘the nation’.

• 1833 Factory Act, this banned children from working in textile factories under the age of nine. From nine to thirteen they were limited to nine hours a day and 48 hours a week.

• The Poor Law (Amendment Act) 1868 rendered parents liable to punishment if they neglected to provide food, clothing or medical aid for their children however this responsibility was ignored by many guardians.

• The 1889 Prevention of Cruelty to Children Act known as the Children’s Charter, was amended and extended to allow children to give evidence in court, mental cruelty was recognised and it became an offence to deny a sick child medical attention.
A GLOBAL AGENDA

Comparing Child-focused Sustainable Development Goals (SDGs) in High-income Countries: Indicator Development and Overview

Dominic Richardson, Zlata Brukauf, Emilia Toczydlowska, Yekaterina Chzhen

Office of Research - Innocenti Working Paper WP:2017-08 | June 2017

“health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity” (WHO)

Fairness for Children
A league table of inequality in child well-being in rich countries
'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)
State of Child Health 2017 –Recommendations for Scotland

1. 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’

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

3. Develop integrated health and care statistics

4. Develop research capacity to drive improvements in children’s health

5. Reduce child poverty and inequality

6. Maximise women’s health before, during and after pregnancy

7. Introduce statutory sex and relationships education at all schools

8. Strengthen tobacco control

9. Tackle childhood obesity effectively

10. Maximise mental health and wellbeing throughout childhood

11. 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’

12. Implementing guidance and standards

Anne Mullin Parenting in Scotland 2018
• The vulnerable child was never far from sight of GPs who in the era of pre-NHS chose to work in impoverished under-doctored areas without the support of a welfare state or unified health service. This was particularly true of the early female GPs who were arguably the Deep End Pioneers of their day.

• They built up large lists of women and child patients by ‘squatting’ in run down premises ‘driven by a strong social conscience to practise in a very poor area...Medical women were less hierarchical in their work ;they did things with their patients not to them’ (Anne Digby, The Evolution of British General Practice)
It began as a small clinic in Glasgow, often sneered at for the work it did to help pregnant women with drug, alcohol, HIV and mental health problems. But the system used at Glasgow Women’s Reproductive Health Service, set up in 1990, has now helped to model similar services around the world. The guidelines and recommendations used by the clinic, now known as the Special Needs in Pregnancy Service (Snips), are now in place UK-wide and internationally recognised as the correct way to treat socially disadvantaged mothers-to-be.


Anne Mullin Parenting in Scotland 2018
‘To be a good enough parent one must be able to feel secure in one’s parenthood, and one’s relation to one’s child...The security of the parent about being a parent will eventually become the source of the child's feeling secure about himself.’

Bruno Bettelheim
‘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

BORN TO FAIL

Are children still experiencing inequality and disadvantage?
Far from improving over time, the situation today appears to be no better than it was nearly five decades ago.

- A child from a disadvantaged background is still far less likely do well in their GCSEs at 16.
- Children living in deprived areas are much more likely to be obese than those living in affluent areas.
- Children from disadvantaged backgrounds are more likely to suffer accidental injuries at home.
- Children living in the most deprived areas are much less likely to have access to green space and places to play.

Overall the inequality that existed 50 years ago still persists today, and in some respects has become worse.
The fact that the poverty and inequality experienced by our children remains just as prevalent today as it did nearly 50 years ago must not be ignored...there is a real risk of sleepwalking into a world where inequality and disadvantage are so deeply entrenched that our children grow up in a state of social apartheid.
'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 Parenting in Scotland 2018
‘End Child Poverty coalition calls for an end to the freeze on children's benefits as new figures released today show that there are some constituencies in the UK today where more than half of children are growing up in poverty. The figures also show that some of the most deprived areas of the UK have seen the biggest increases in child poverty since the coalition’s last local child poverty figures for December 2015. The coalition is also concerned that the impact of poverty may be exacerbated by a poverty premium... low income families can face paying as much as £1700 per year more than better off families, to buy the same essential goods and services. A major contributor to this is the high cost of credit for low income families, and the coalition wants to see the Government address this by providing better access to interest free credit.’

<table>
<thead>
<tr>
<th>Constituency</th>
<th>% of children in poverty 2017 (after housing costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bethnal Green and Bow</td>
<td>54.18%</td>
</tr>
<tr>
<td>2. Birmingham, Ladywood</td>
<td>53.06%</td>
</tr>
<tr>
<td>3. Poplar and Limehouse</td>
<td>52.75%</td>
</tr>
<tr>
<td>4. Birmingham, Hodge Hill</td>
<td>51.46%</td>
</tr>
<tr>
<td>5. Manchester, Gorton</td>
<td>47.97%</td>
</tr>
<tr>
<td>6. Birmingham, Hall Green</td>
<td>47.82%</td>
</tr>
<tr>
<td>7. Manchester Central</td>
<td>47.52%</td>
</tr>
<tr>
<td>8. Bradford West</td>
<td>47.26%</td>
</tr>
<tr>
<td>9. Bradford East</td>
<td>46.73%</td>
</tr>
<tr>
<td>10. Oldham West and Royton</td>
<td>45.58%</td>
</tr>
<tr>
<td>11. Edmonton</td>
<td>45.39%</td>
</tr>
<tr>
<td>12. Glasgow Central</td>
<td>45.06%</td>
</tr>
</tbody>
</table>
Poverty and children’s health: views from the frontline

- ‘[We] see parents in A&E who are limiting their eating to care for their children. Children are worried, scared and upset.’
- ‘Many of our [patients] are from low income families who rely on food banks’
- ‘I see many disabled children who are living in inadequate housing which causes significant stress to families, back problems through having to lift children, etc.’
- ‘Single mother evicted from rented property given accommodation in a Travelodge in another town. The child had multiple allergies. Could not afford decent meals.’
- ‘Families on lower incomes are not able to provide the opportunities which may directly impact health – for example continuous glucose monitoring devices; healthy food; sports and other activities’
- ‘Issues that could and should have been managed by routine universal services (such as parenting support) have not been due to service cuts, and therefore we see families when they have reached crisis point.’
- ‘Financial worries are a huge concern for many of our families and have an impact on parents’ mental health and their ability to cope with challenging circumstances’
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

If a child arrives at school hungry once a week they will lose 70 per cent of a term over the whole of their primary school education.
Good Childhood Report 2017

However, there is an increasing gap emerging between the scale of the need and the funding available for local authorities to help children and families deal with these problems. The Government must urgently review the funding available for local authority children’s services in order to equip them to adequately address the scale of demand.

HISTORICAL AND GENERATIONAL TRAUMA - EPIGENETIC CONSEQUENCES OF TOXIC STRESS
TOXIC STRESS CAUSED BY ACES CAN ALTER HOW OUR DNA FUNCTIONS.
THAT CAN BE PASSED ON FROM GENERATION TO GENERATION
NOT ONLY ASKING: "WHAT HAPPENED TO YOU?", ALSO ASKING"WHAT HAPPENED TO YOUR PARENTS?" TO YOUR GRANDPARENTS?
TO YOUR GREAT-GRANDPARENTS? TO YOUR TRIBE, ETHNIC GROUP, ETC.?

CREATING HEALTH-PROMOTING ENVIRONMENTS FOR ADOLESCENTS WILL ULTIMATELY REQUIRE ENGAGEMENT WELL BEYOND THE HEALTH SECTOR, WITH EDUCATION, LOCAL GOVERNMENT, INDUSTRY, RELIGIOUS LEADERS, CIVIL SOCIETY AND YOUNG PEOPLE THEMSELVES ALL ESSENTIAL ACTORS. IN A WORLD OF COMPETING POLICY PRIORITIES, THERE IS NO DOUBT THAT PROVIDING THE RESOURCES FOR HEALTHY ADOLESCENT GROWTH, EDUCATION AND EMOTIONAL DEVELOPMENT WILL YIELD LARGE BENEFITS FOR CURRENT AND FUTURE GENERATIONS.

Anne Mullin Parenting in Scotland 2018
Adolescence and the next generation doi:10.1038/nature25759
We Know the Answers!

**CHILD POVERTY**

In Glasgow and Scotland:
- 1 in 3 children were estimated to be living in poverty in 2017.
- That's over 37,000 children living in poverty in Scotland's biggest city.
- The percentage of children living in poverty is higher in Glasgow than in Dundee, Edinburgh and Aberdeen.
- 34% in Glasgow, 28% in Dundee, 22% in Edinburgh, and 17% in Aberdeen.

Overall, 1 in 3 Scottish children (210,000) are growing up in relative poverty.

**Early years children and young people: What is needed to support a healthy start in life?**

- Adequate family income and actions to mitigate impacts of poverty and inequalities.
- Strong bonds and positive relationships with caregivers and across schools and communities.
- Safe, nurturing environments which enable learning and play.

Check out further information on this topic, as well as more on Glasgow's population health here: www.understandingglasgow.com

Find out more about this research on our website: www.gcpb.co.uk/publications/08_health_and_early_years_children_and_young_people_a_gcpb_synthesis
<table>
<thead>
<tr>
<th>Measure</th>
<th>Govan/ Linthouse</th>
<th>WhiteCraigs</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>

Sources:
- http://www.scotpho.org.uk
THE GENEALOGY OF THE OBESITY CRISIS

Reproduced with the permission of David Blane
RISKY PLAY – ARE WE READY TO TAKE THAT LEAP?

Anne Mullin Parenting in Scotland 2018

‘injuries are an inevitable side effect of physical activity, which is necessary for a healthy and active lifestyle...children in an experimental group exposed to a 14-week risky play intervention improved their risk detection and competence, increased self-esteem and decreased conflict sensitivity, The vast majority of risky outdoor play-related injury incidents result in minor injuries requiring minimal or no medical treatment

Risk minimised by:
• Adult Supervision
• Playground Safety Standards

The more risks you allow children to take, the better they learn to take care of themselves. -Roald Dahl

As at 31 July 2016, **17,349** children in Scotland were looked after or on the child protection register.

2,723 total on child protection register

15,317 total looked after

691 both

2% Looked after or on the child protection register

### A Sense of Proportion

<table>
<thead>
<tr>
<th>SHIP Practice Patients ≤1Y</th>
<th>ALL</th>
<th>SHIP</th>
<th>N=90 SHIP</th>
<th>SHIP (as %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>120</td>
<td>100</td>
<td>100</td>
<td>10.7%</td>
</tr>
<tr>
<td>Male</td>
<td>1302</td>
<td>153</td>
<td>1169</td>
<td>11.0%</td>
</tr>
<tr>
<td>Total</td>
<td>1422</td>
<td>253</td>
<td>2269</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

### Comparisons with 2014-15:

- 88 young people were in secure care accommodation
- 1% decrease in number of children looked after
- 1% decrease in number of children on child protection register
- 3 more residents, on average, during the year in secure care accommodation

<table>
<thead>
<tr>
<th>500 Social Work Stats Children ≤1Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked after away from home</td>
</tr>
<tr>
<td>Looked after at home</td>
</tr>
<tr>
<td>Placed on EP register</td>
</tr>
<tr>
<td>12/10/16 (SOUTH CHP)</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>AGEBAND</td>
</tr>
<tr>
<td>0-4 years</td>
</tr>
<tr>
<td>5-9 years</td>
</tr>
<tr>
<td>10-12 years</td>
</tr>
<tr>
<td>13-15 years</td>
</tr>
<tr>
<td>&gt;16 years</td>
</tr>
<tr>
<td>TYPE OF PLACEMENT</td>
</tr>
<tr>
<td>Foster care</td>
</tr>
<tr>
<td>Children’s Unit</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>With Parents</td>
</tr>
<tr>
<td>Kinship</td>
</tr>
<tr>
<td>Scotland’s Population Children &amp; Young People 2016</td>
</tr>
</tbody>
</table>
SUPPORTING PARENTS & CHILDREN- WHERE SHOULD WE BE LOOKING?
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)

Anne Mullin Parenting in Scotland 2018
Addressing childhood adversity and trauma

WHAT IS ADVERSITY?

Adverse Childhood Experiences (ACEs) are highly stressful and potentially traumatic, events or situations that occur during childhood and/or adolescence. It can be a single event, or prolonged threats to, and breaches of, a young person’s safety, security, trust or bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.

Adaptations are children and young people’s attempts to:
- Survive in their immediate environment
- Find ways of mitigating or tolerating the adversity by using available resources
- Establish a sense of safety or control
- Make sense of the experiences they have had

WHAT KINDS OF EXPERIENCES ARE ADVERSE?

Forms of ACEs include:
- Maltreatment
  - i.e. abuse or neglect
- Violence & coercion
  - i.e. domestic abuse, gang membership, being a victim of crime
- Adjustment
  - i.e. migration, asylum or ending relationships
- Prejudice
  - i.e. LGBT+ prejudice, sexism, racism or ableism
- Household or family adversity
  - i.e. substance misuse, intergenerational trauma, domestic or institutionalisation
- Inhumane treatment
  - i.e. torture, forced imprisonment or institutionalisation
- Adult responsibilities
  - i.e. being a young carer or involved in child labour
- Bereavement & survivorship
  - i.e. traumatic deaths, surviving an illness or accident

HOW COMMON ARE ACEs?

Around half of all adults living in England have experienced at least one form of adversity in their childhood or adolescence.

Of all children and young people:
- 52% experienced 0 ACEs
- 23% experienced 1 ACE
- 16% experienced 2-3 ACEs
- 9% experienced 4+ ACEs

HOW DOES IT IMPACT THE LIVES OF YOUNG PEOPLE?

ACEs impact a child’s development, their relationships with others, and increase the risk of engaging in health-harming behaviours, and experiencing poorer mental and physical health outcomes in adulthood. Compared with people with no ACEs, those with 4+ ACEs are:
- 2x more likely to binge drink and have a poor diet
- 3x more likely to be a current smoker
- 4x more likely to have low levels of mental wellbeing & life satisfaction
- 5x more likely to have had underage sex
- 6x more likely to have an unplanned teenage pregnancy
- 7x more likely to have been involved in violence
- 11x more likely to have used illicit drugs
- 11x more likely to have been incarcerated

NEW KID ON THE BLOCK
WHAT PROTECTS YOUNG PEOPLE FROM ACES?

Not all young people who face childhood adversity or trauma go on to develop a mental health problem. There are personal, structural and environmental factors that can protect against adverse outcomes, as shown in the protection wheel opposite.

WHAT CAN WE DO ABOUT IT?

Commissioners can address childhood adversity and trauma by:

1. Making childhood adversity and trauma a local commissioning priority
2. Creating a common identification and enquiry framework for identifying need
3. Investing in adversity and trauma-informed models of care

Anne Mullin Parenting in Scotland 2018

GENERAL PRACTICE BRICOLAGE.
SUPPORTIVE FAMILY PRACTICE – IT’S AN ARTFUL SCIENCE

The essential ingredients for general practice to make a difference.
CONSULTATIONS, CARING, CONTINUITY,
COVERAGE, CAPACITY, COMMUNITY,
COORDINATION,
CREATIVITY, COMMITMENT,
COLLEGIALITY, CONSISTENCY AND CAMPAIGNING (Graham Watt)

What Patients Want;
• CARING AND COMPASSIONATE STAFF AND SERVICES
• CLEAR, EFFECTIVE COMMUNICATION AND EXPLANATION ABOUT CONDITIONS AND TREATMENT
• EFFECTIVE COLLABORATION BETWEEN CLINICIANS, PATIENTS AND OTHERS
• A CLEAN AND SAFE ENVIRONMENT
• CONTINUITY OF CARE
• CLINICAL EXCELLENCE.

NHS Healthcare Quality Strategy
Anne Mullin Parenting in Scotland 2018
It’s Not All About Ticking a Box For Clicky Hips and Heart Murmers!

GPs have a minimal role in child health surveillance in Scotland since 2006 - a single assessment at 6-8 weeks focussed on physical examination.

Coverage of the 10 day review is high (99%), but it progressively declines for reviews at older ages (86% for the 39–42 month review).

Coverage is lower in children living in the most deprived areas for all reviews, and the discrepancy progressively increases for reviews at older ages (78% and 92% coverage for the 39–42 month review in most and least deprived groups).

The inverse care law continues to operate in relation to ‘universal’ child health reviews. Equitable uptake of reviews is important to ensure maximum likely impact on inequalities in children’s outcomes. Wood et al http://dx.doi.org/10.1136/bmjopen-2011-000759
KEEP THE BABY IN THE BATHWATER

Prior to the changes to the CHS system, GPs often contributed to CHS reviews at 6–8 weeks and 8–9 and 39–42 months. Following the changes, **GP provision of the 6–8 week review continued but other reviews essentially ceased.** Few additional consultations with pre-school children are recorded as involving other aspects of preventive care, and the changes to CHS have had no impact on this. In the 2½ years before and after the changes, consultations recorded as involving any form of preventive care accounted for 11% and 7.5% respectively of all consultations with children aged 0–4 years, with the decline due to reductions in CHS reviews.

Effective preventive care through the early years can help children secure good health and developmental outcomes. GPs are well placed to contribute to the provision of such care.

Consultations focused on preventive care form a small minority of GPs’ contacts with pre-school children, however, particularly since the reduction in the number of CHS reviews.

Anne Mullin Parenting in Scotland 2018
WHAT DOES THE ‘TROUBLED FAMILY’ LOOK LIKE?

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 caregiver.

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 (Deep End Report 23).
Shining a light on what can be learned from new care models to change in the NHS (Starling, The Health Foundation)

1. Start by focusing on a specific population.
   - 2. Involve primary care from the start.
   - 3. Go where the energy is.
   - 4. Spend time developing shared understanding of challenges.
   - 5. Work through and thoroughly test assumptions about how activities will achieve results.
   - 6. Find ways to learn from others and assess suitability of interventions.
   - 7. Set up an ‘engine room’ for change.
   - 8. Distribute decision-making roles.
   - 9. Invest in workforce development at all levels.
   - 10. Test, evaluate and adapt for continuous improvement.

Anne Mullin Parenting in Scotland 2018
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. Loss of organisational memory
- Clunky communication systems - an ongoing frustration
- Fragmented data systems
- GP contract - minimises maternity, paediatric and family health care
- No specific role for GPS in care of vulnerable children & families despite being the ‘hub’ and point of contact for other services / outside agencies
- Vulnerable adults often don’t reach thresholds of service provision. Boundaries to service provision are barriers to access to service
- Very little research to argue our case. GPS don’t write things down, difficult to quantify ‘non events’
- Experience doesn’t seem to count

HORIZON 3 SAILING ON CALM WATERS

- Protected time - Case planning
- Professional relationships - face-to-face discussions - blurring the boundaries – all working as generalists,
- Infrastructure - e.g. MDT meetings, JSTs, whole systems approach, 1Y & 2Y care interface, steering group
- Multimorbidity database
- Documentation - minuted meetings, diaries admin support
- Patient engagement
- Research that fits working practices (e.g. evaluation report)
- Bigger picture - links workers, mental health, education, 3Rs sector management (understanding budgetary constraints and planning networks)
- Normalising the project work through connectivity, embedded knowledge, knowledge exchange – an ecology of learning

Anne Mullin Parenting in Scotland 2018
Putting It All Together – SHIP MDT

- Workstreams
  - Children & Families
  - Frail & Elderly
  - Unscheduled Care
  - Information Management
  - Other

- Social Care Worker
- Mental Health
- District Nurse
- Health Visitor
- Rehabilitation/Physiotherapist
- Links Worker
- FOCUS Patient / Client Child/Parent /Family unit
- General Practitioner (GP)

As Required
- 2y care
- Education
- Housing
- Carer Support
- Welfare
- Well being
- Social isolation

Anne Mullin Parenting in Scotland 2018
Case 1 ‘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.’

Case 2 ‘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.’
That Jigsaw Thing

- EVERY CHILD, EVERY CHANCE
- GIRFEC
- EARLY YEARS FRAMEWORK
- REFRESHED FRAMEWORK FOR MATERNITY CARE SCOTLAND
- NATIONAL PARENTING STRATEGY
- EARLY YEARS COLLABORATIVE + RAISING ATTAINEMENT FOR ALL=CYPIC
- BOOK BUG
- BABY BOXES
- NAMED PERSON
- EARLY LEARNING AND CHILD CARE
- CHILDREN AND YOUNG PEOPLE (SCOTLAND) ACT 2014

THE WELLBEING OF PEOPLE AND COMMUNITIES IS CORE TO THE AIMS AND SUCCESS OF COMMUNITY.
A STRONG AND THRIVING GENERAL PRACTICE IS CRITICAL TO SUSTAINING HIGH QUALITY UNIVERSAL HEALTHCARE AND REALISING SCOTLAND’S AMBITION TO IMPROVE OUR POPULATION’S HEALTH AND REDUCE HEALTH INEQUALITIES. EQUALITIES AND SOCIO ECONOMIC IMPACTS ARE UNDER CONSIDERATION GPS WILL BE MORE INVOLVED IN INFLUENCING THE WIDER SYSTEM TO IMPROVE LOCAL POPULATION HEALTH IN THEIR COMMUNITIES (Primary Care Improvement Plan)
Safeguarding in general practice has the potential to use core ‘family doctor’ skills to meet the health needs (in the widest sense of the term) …young people, and their families and doing so in tandem with statutory child protection responses…Models of care that promote continuity of care and a holistic approach are likely to facilitate effective GP responses to these children and their families.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4141592/
THANKYOU! ANY QUESTIONS?