Improving general practice – a call to action

Response from the National Children's Bureau

Introduction

Getting primary care right for children and young people is crucial. Young children are particularly frequent users of primary care services and present particular challenges in identifying and treating sickness. Young people have much to benefit from good interaction with their GP in helping them learn to manage and look after their health and independently access other health services as they grow up.

In June of this year NCB published *Opening the door to better healthcare: Ensuring general practice is working for children and young people.*[1] The report examined available evidence on how well general practice is delivering for children and young people, including evidence on their experience of services and the particular challenges they face in accessing them. It also set out a range of priorities for change to help address these challenges.

This response recalls much of the evidence and priorities set out in *Opening the Door to Better Healthcare*, set out under the relevant headings of the questions pose by NHS England's "call to action".

Information, choice and control

Collective engagement and information

Children have historically been left out of most patient involvement and insight mechanisms. The GP Patient Survey is a key measure of patients' satisfaction with their primary care services, but only collects the views of those aged 18 and over. Furthermore it does not explicitly ask parents about their views on the services provided for their children, or report separately on this. This is crucial, as children under 5 visit the GP around 6 times every year on average[2] – around twice as much as older children - and account for most of the increases in emergency admissions of children[3].

The Children and Young Peoples Health Outcomes Forum has recommended that the NHS Outcomes Framework be improved to better reflect children's views, including through extending the indicator on experience of GP services and other indicators measured by the GP Patient Survey to cover children.[4] It has been

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[1] NCB (2013), *Opening the door to better healthcare: Ensuring general practice is working for children and young people,* http://www.ncb.org.uk/what-we-do/policy/thematic-policy-reports

[2] Health and Social Care Information Centre (2009), *Trends in Consultation Rates in General Practice - 1995-2009*

[3] Gill PJ *et al* (2013), "Increase in emergency admissions to hospital for children aged under 15 in England, 1999-2010: national database analysis", *BMJ*, Volume 98, Issue 5.

[4] *Report of the Children and Young People's Health Outcomes Forum*, pp29-30

suggested that the Friends and Family Test could be rolled out for children from 2015. **It will be important that such mechanisms are used in all care settings, including GP services, and that they reflect the quality of care received by children and young people of all ages.**

There are also a number of barriers children and young people face in taking part in GP practices' Patient Participation Groups. Firstly some groups expressly forbid membership for those aged under 18 or 16.[5] Secondly many run a membership system sometimes of limited numbers of patients which may be less amenable to children and young people's often busy and fast changing lives or indeed those of working parents/parent-carers. To receive additional funding for these groups in 2013/14, practices will need to demonstrate how they have engaged in a way that is representative of all registered patients.[6] **Implementation of this requirement going forward should take into account how well children, young people and their families are engaged. NHS England should also support children and young people's involvement in their commissioning of primary care both locally and through the Youth Forum being set up in partnership with the British Youth Council.**

Individual engagement

We welcome the Government's proclamation that **the concept of no decision about me, without me applies equally to children as it does to adults.[7] How GP's work with children and young people is key to making this a reality, but more support and training is needed.**

Good trust and communication with their GP is key to making sure children and young people are involved in decisions about their care in a way that is appropriate to their age, maturity and communication needs. Under Article 12 of the UN Convention on the Rights of the Child, children and young people have a right to have their views heard on issues that affect them.[8] Supporting children and young people to understand their health and be involved in decisions can also help improve outcomes. Studies have found that in the case of young people with asthma involvement can increase feelings of self control and reduce absenteeism

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[5] As demonstrated by example terms of reference/constitutions that can be found on the NAPP website http://www.napp.org.uk/constitutions.html [Accessed 14/05/2013]

[6] NHS Employers, NHS England and British Medical Association (2013) *2013/14 patient participation directed enhanced service guidance*

[7] Department of Health (2012) Government response to the consultation on proposals for greater patient involvement and more choice https://www.gov.uk/government/publications/government-response-to-the-consultation-on-proposals-for-greater-patient-involvement-and-more-choice

[8] The United Nations Convention on the Rights of the Child, Article 12 (1). The UK is a signatory to this convention and as such Government is committed to implementing it. http://www.unicef.org.uk/UNICEFs-Work/Our-mission/UN-Convention/

from school and visits to A & E. There is also evidence that it supports the effective treatment of diabetes in children. [9,10]

A common theme in studies of children's experience of health services, however, is a perception that the child is not being involved in decisions about their care and that health professionals do not communicate in a way that is young person friendly.[11] There is a sense that for vulnerable groups, such as children seeking asylum or care leavers, these can be particular challenges when accessing GP services. [12] These groups in particular, as well as children and young people on the whole, find it difficult to talk about mental health issues with their GP. Over a third of those surveyed by the UK Youth Parliament said they would not consult their GP about particular issues such as sexual health, adolescent concerns, mental health, and weight. A significant proportion of young people appear to be generally uncomfortable talking to their GP.

Some health professionals have reported that they feel only able to take an all-or-nothing approach to children's participation in their care, as they do not have the confidence or tools to take a more nuanced approach as the child matures.[13] In many cases the default will be to only discuss things with the parent.

If more time is needed for a child's history or needs to be explained to a new doctor or for the child to be involved in discussions about their health this will often be obstructed by strict rules about the length of appointments (typically ten minutes) and to whom double appointments are made available. Having a follow up appointment with a practice nurse to support understanding of what has been agreed with the GP may be an option but young people and children's families may not understand how to do this – or appointment booking systems may not facilitate it.

The quality of communication between a child or young person and their GP also links back to the training that the GP has received and whether there is a child health lead in the practice able to support children who want to get involved and their colleagues to facilitate this.

Clinical leadership and innovation

There are many examples of clinically lead innovation to better meet children's health needs in out of hospital settings. Some of these shift more child health expertise into GP practices, through deployment of GPs with special interest or advanced pediatric nurses, or into integrated centres bringing together primary,

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[9] Guevara, JP *et al* (2003), "Effects of educational interventions for self management of asthma in children and adolescents: systematic review and meta-analysis", *BMJ*. 2003 June 14; 326(7402): 1308.

[10] Alderson, P *et al* (2006), "Children as partners with adults in their medical care", *Arch Dis Child*. 2006 April; 91(4): 300–303.

[11] Lavalle *et al* (2012), *Listening to children's views on health provision – A rapid review of the evidence,* NCB

[12] See Children's Experience of GP services, above

[13] Council for Disabled Children (2011), *Managing My way,* p22

acute and public health sectors. Others take more basic steps in access, such as drop in sessions for young children or holding surgeries in schools.

These examples appear to be more the exception than the rule, however, and there is too much variation in the quality of services for children and young people and in primary care related outcomes between different GP surgeries and their local areas.

Before embarking on a new approach, particularly in the context of difficult funding situations and rising pressure on the NHS as a whole, clinicians or commissioners may understandably want to be sure of the potential impact of the change they are considering. This can be helped by two things. Firstly, learning from others. Being able to compare and contrast innovations that are being used by colleagues according to their aims and the demographic and organizational contexts in which they are being taken forward might help consideration of the appropriateness or applicability to another area. **In addition to the collation of innovative practice examples, those CCGs and member practices that are rich in expertise in meeting children and young people's needs and have been driving forward innovation in their local areas must come together to provide peer support for driving forward improvements in primary care across the country.**

Secondly, a data infrastructure that can link innovations to patient outcomes and experiences, and enables innovators to demonstrate the need for change and the impact of their work would also help. This can be particularly challenging in making improvements for children. This is because many national data collections, particularly on patient experience do not include children, but also because the outcomes that are to be improved may be long term and spread across into different service domains such as education or youth justice. **Data on children and young people's health and wellbeing, the long term traceability of outcomes and interoperability across domains needs to be improved. This should include implementation of the Children and Young People's Health Outcomes Forum recommendation that the NHS Number should be used as the unique identifier to bring together health, education and social care data for all children and young people.**

Freeing up time and resources

Quality and Outcomes Framework

Only 3% of the QOF's total scoring system relates to the care of children. RCGP have recognised this as a challenge to be addressed.[14] The Children and Young People's Health Outcomes Forum has also described this representation as "unacceptably small" and has recommended prioritisation of the development of an appropriate range of incentives within the QOF for general practice to provide high quality care reflecting the needs of children and young people.[15] In *Opening the Door to Better Healthcare* we called for the QOF, as long as it remains a lever for service improvement, to better reflect improvements to meet children and young

[14] It covers child health checks, child protection and the clinical care for asthma for those 8 years old and over. Royal College of General Practitioners (2010), *RCGP Child Health Strategy 2010-15*, p7

[15] *Report of the Children and Young People's Health Outcomes Forum*, p67

people's needs and for amendments to this end to be considered every time the Framework is reviewed.

Below we discuss the scope for more responsiveness to local needs and opportunities in commissioning of GP services and how this might address some of the issues children face in using these services. When considering how the QOF may be amended to free up resources and allow room for local responsiveness, it will be important to ensure that children's needs are not overlooked. **Any revised QOF must proportionately reflect the provision of good services for children and not create incentives to de-prioritise improvements their care.**

Practice Staff

Practice staff other than GPs can have a key role in improving children and young people's experience of using primary care services. As suggested above practice nurses could play a role in supporting young people to understand their health and prepare for or follow up on appointments with the doctor. Specialist nurses are also playing a role in some innovative programmes to deploy more child health expertise in the community and partnerships between GPs, midwives and health visitors are key to ensuring all children get a healthy start. Practice managers and receptionists can play a key role in making practices accessible and welcoming for children and young people. Children and young people's experience of visiting the GP surgery is one of the challenges we explored in *Opening the Door to Better Healthcare.* Some young people who are uncomfortable visiting their GP say that this is because they do not know how to make an appointment; some young people have described reception staff as over inquisitive; and some practices have been known to refuse to allow younger teenagers to consult alone.[16,17,18]

Market management, investment and the GP Contract

In our report, *Opening the Door to Better Healthcare*, we explored the commissioning landscape for primary medical care and observed an apparent lack of process for aligning the provision of services with the needs of local communities in the process. Alongside training, this appears to be a key factor in preventing the best care being provided for children and young people across the country.

One way in which local commissioners may be able to respond to local circumstances is for urban areas to have configurations of larger practice or practice groups, able to offer longer or more varied opening hours and secure a good range of medical expertise and special interest.

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[16] *NCB (2012): Teenagers' views on their health and local health services*

[17] Cameron, C. (2007), "Access to health services: Care leavers and young people 'in difficulty'." ChildRight **238**: 22-25. Cited from *Listening to children's views on health provision*, p23

[18] Royal College of General Practitioners (2010), *RCGP Child Health Strategy* 2010-15, p10

Current arrangements for practice opening hours mean that parents of younger children will be confused about where to go to when they have concerns about their child's health, encouraging them to resort to A & E unnecessarily. There does indeed appear to be an increase in the rate of children attending A & E during evenings.[19] Working parents may particularly struggle to take their child to surgery during its normal opening hours for less urgent appointments and may default to A & E when they finish work or if the child's condition deteriorates. For school aged children, the number of appointment slots available outside of school hours in the early evenings and at weekends is also reduced by these arrangements. This means that children are more likely to have to take time out of school even for routine or non-urgent appointments. A spell of illness or a long term condition requiring several such appointments could mean several missed lessons that a child may not be able to catch up on and, ultimately, avoidable harm to their educational outcomes. We made clear in our submission to Monitor's call for evidence earlier in the year that a system which distinguishes 'out of hours' services using nationally set parameters that bear no relation to local demand is a particularly striking obstruction to delivering the best primary care for children and young people, and may serve to compound the challenge for other services in meeting demand.

The Children and Young People's Health Outcomes Forum made a number of recommendations including that all general practices that see children and young people should have a named medical and nursing lead.[20] These leads would be able to help maintain the expertise of each practice and ensure that procedures remain in line with the latest regulations and guidance, for example on safeguarding, coordinating health and special educational needs services or use of medicines. The System-wide Response to the Forum sets out the Royal College of General Practitioners' support for this recommendation and their commitment to NHS England, the Department of Health, the General Pharmaceutical Council (GPC) and others to consider this proposal in more detail.[21]

It is understandable that identifying a medical and nursing lead for children and young people would be particularly challenging for smaller practices, as would offering longer opening hours. While there may be many advantages and disadvantages to different sizes of practice, the main advantage of smaller practices is that in areas of low demand, such as rural areas, they can be more spread out to allow for patients to access the surgery without travelling long distances. One would expect, therefore, for the proportion of single and double-handed practices to be higher in rural areas. The map included in the evidence pack to aid this

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[19] Ian Kennedy (2010), *Getting it right for children and young people Overcoming cultural barriers in the nhs so as to meet their needs*, p21

[20] REPORT OF THE CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM, p54 https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results

[21] Department of Health (2013) *Improving Children and Young People's Health Outcomes: a system wide response*, p40

consultation, however, shows that if anything, the reverse is true.[22] This suggests that **there is clearly scope for a more locally responsive approach to commissioning primary care and that, as long as this is not exploited, children and young people's outcomes and experiences of care may be unnecessarily damaged.**

As well as being responsive to local needs and opportunities, it is also **important that unexplained variations in the quality of care for children and young people are better addressed**. A & E attendance rates, while influenced by a number of factors, may be an indicator of the quality of local GP services, especially as much of the recent increases in emergency admissions of children are accounted for by ailments amenable to primary care. [23] The evidence shows that while rates of A & E attendance are strongly influenced by deprivation, there is also significant variation between areas that cannot be explained in this way[24]. The Royal College of GPs also identified in 2010 "a marked variation in the quality of care provided for young people (10-19 years) in general practice; ranging from practices who fail to recognize their ethical responsibilities by refusing to allow younger teenagers to consult alone, to those which provide specific services for their young people and nurture strong links with local schools."[25] While it is always important to support providers who want to provide the best care and may benefit from guidance or peer support, addressing these challenges may also involve NHS England using stronger influence as a commissioner to ensure that their finite budgets are being spent on the best services attainable.

As we have set out in *Opening the Door to Better Healthcare*, NCB calls for:

- **Any forthcoming contract renegotiation between NHS England and GPs to put the needs of children, young people and families centre-stage and make clear progress on key issues such as practice opening hours**
- **There to be confidence that, whoever hold contracts with GPs, and however they are negotiated, that this promotes:**
    - **Consideration of local needs and opportunities for improvement in the provision of primary care for children and young people**

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[22]NHS England Analytical Service(2013) *Improving General Practice – a call to action Evidence pack,* p40

[23] Gill PJ *et al* (2013), "Increase in emergency admissions to hospital for children aged under 15 in England, 1999-2010: national database analysis", BMJ, Volume 98, Issue 5.

[24] *Cheung R (Ed.). NHS Atlas of Variation in Healthcare for Children and Young People. 2012. NHS Right Care p74*

[25] RCGP (2010) *RCGP Child Health Strategy 2010-2015, pp9-10*

- **Identification and rollout of good practice, particularly in reducing A & E attendances**
- **A robust focus on the needs of the children, young people and the wider population rather than service providers**
- **Partnership working with secondary care and primary care-oriented aspects of public health services**

- **NHS England to engage with Health and Wellbeing Boards to get the best out of their local GP practices for children and young people.**

Workforce development

The overall level and consistency of child health expertise available in GP practices can often make effectively communicating with, diagnosing, treating and supporting children more of a challenge than it should be.

Dealing with relatively common mental health concerns among adolescents is a particular area where the right expertise may not exist amongst all GPs. A research review found that young people with mental health problems felt that many GPs lacked understanding, awareness, empathy and interest, and were reluctant to provide certain types of support.[26]

Children who have a long term health condition and/or disability will often go straight to their consultant paediatrician for their health concerns. Some of these encounters with the hospital paediatrician will be for ailments such as coughs and colds that effect all children and young people and may not necessarily require such specialist attention. Three quarters of parents of disabled children surveyed by Contact a Family in 2011 said that their child's GP had no role in their care.[27]

It is also worth noting the observation made by the Child Health and Maternity Partnership in 2011 that some of the areas with the highest rates of emergency admissions are areas which have standalone children's hospitals.[28] This may be indicative of parents in such areas believing that these hospitals are the place to get the best care for their children. It may also be indicative of an over reliance in primary care on such services to care for acutely sick children and/or a 'siloed' approach to provision which results in admission being the only way to access the expertise they host.

It is for all these reasons that we call for the following:

- **Confirmation of funding for the implementation of the Royal College of GPs' proposal to extend GP training - including child health as core element**
- **Existing GPs to be offered adequate opportunities to develop their skills, expertise and experience in working with children and young**

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[26] Lavis, P. and L. Hewson (2010), "How many times do we have to tell you? "Young Minds Magazine **109**: 30-31. Cited from *Listening to children's views on health provision*, p34

[27] Contact A Family (2013), *Making GP practices more welcoming for families with disabled children: Information for GP practice teams*

[28] Andrews (2011), *Fundamentals of Commissioning health Services for Children*, Child Health and Maternity Partnership, p8

people. Many organisations may have a part to play in this, including Local Education and Training Boards, Royal Colleges, Health Education England and the voluntary and community sector

- **NHS England to use its role as commissioner of primary care to incentivise GPs to take up these opportunities and for trainee GPs to seek out opportunities to maximize their experience of working with children and young people**
- **Expertise in other services to be exploited through partnerships with secondary care and public health and the services of a range of professionals such as community children's nurses, health visitors, school nurses and GPs all to contribute to a joined up primary care offer for children and young people.**

Implementation of the recommendation of the Children and Young People's Health Outcomes Forum for all practices to have a medical and nursing lead for children (as discussed in the section above) will also help to address some of these issues.

About NCB

The National Children's Bureau is a leading research and development charity that for 50 years has been working to improve the lives of children and young people, reducing the impact of inequalities. We work with children, for children to influence government policy, be a strong voice for young people and front-line professionals, and provide practical solutions on a range of social issues.

For more information visit www.ncb.org.uk

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