Scrutiny of the Draft Budget 2012-13 and Spending Review 2011

NHS Greater Glasgow and Clyde

Submission to the Finance Committee

1. Introduction

1.1 We welcome the opportunity to respond to this call for evidence. Our response is informed by the detailed evidence and references provided in the following reports:
- The Chief Medical Officer for Scotland’s evidence to the inquiry into preventative spend
- New Economics Foundation report Backing the Future: why investing in children is good for us all
  http://www.actionforchildren.org.uk/media/143372/backing_the_future.pdf
- ‘Mind the Gaps – Improving Services for Vulnerable Children.  NHSGGC (attached at Appendix 2).

1.2 NHSGGC responded to the call for evidence for the inquiry into preventative spend, and we note the subsequent report from that committee. Rather than repeating our comments, we have focused on particular areas which we believe need to be addressed within the September budget. These are:
- The NHS role in early years support and intervention, particularly for vulnerable families.
- The continuation and extension of specific health improvement activity in relation to smoking, alcohol and obesity.
- Reshaping Care for Older People.

1.3 Government action to support these needs to include both funding and wider legislative, governance and accountability arrangements to support investment in issues with a long term economic benefit which may accrue across multiple agencies.

1.4 The table at appendix 1 summarises the main issues we would like to see supported in the draft budget in relation to preventative spend, including the action required and suggested indicators.

2 Early intervention

2.1 The evidence base for early intervention, the potential range of services and the expected long term savings are clear and undisputed and have been the subject of extensive review. Our comments therefore focus on the role of NHS services in this regard.
2.2 *The Financial Impact of Early Years Interventions in Scotland (part 2)* describes a package of measures which might form a comprehensive package of early intervention. A number of these require delivery by the NHS, including family nurse partnership and equivalent interventions, antenatal support for substance misuse, pre-school child health weight interventions and smoking cessation in pregnancy.

2.3 The NHS – specifically General Practice, midwifery and health visiting – provides the universal contact point for pregnant women and young children. There is therefore significant potential for health services to identify and assess risk and ensure that engagement and early intervention is in place in the antenatal period and in early childhood for vulnerable families. In order for this to happen, health services have to have a clear resource to support vulnerable families and to be able to quickly organize intensive support from necessary services to be put in place. This could involve, for example, midwives and health visitors being able to directly access family support from other agencies including social work and early education services. We would strongly support a greater shift of responsibility and resources for intensive family support from Local Authorities to the NHS.

2.4 We also note that *The Financial Impact of Early Years Interventions in Scotland (part 1)* identifies that savings from early intervention only accrue in part in the short term to the NHS. The more significant savings are to Local Authorities in terms of social work support and impact of lack of school readiness in the short term, and to Local Authorities and criminal justice services in the medium term. Any provision for early intervention in the draft budget must therefore address the issue of how funding can be moved between different organisations.

2.5 While we have some good examples of progress in this area, for example the investment in a comprehensive positive parenting programme in NHSGGC in partnership with Local Authorities, this has largely relied on additional or unallocated development funding rather than a different use of core funding. As challenges to public sector funding continue, this will no longer be sustainable unless agencies reduce or cease some services to less needy groups.

2.6 We note the Christie Commission report and await further guidance from Scottish Government on integration of health and social care. It is our view that a clearly defined model with single accountability for services and budgets would greatly support moves to early intervention.

2.7 In terms of indicators, a number of outcomes indicators relating to child poverty and vulnerable children already exist, but need to have much higher prominence and pressure to ensure that they drive change across all agencies. Indicators for early years could include:
- developmental measures (including language) as identified at the 30 month assessment.
- readiness for school, as assessed at school entry.
- child poverty indicators.
- low birth weight and early access to antenatal care.
- availability and affordability of high quality nursery places.
- continuing to measure immunisation uptake.

3. Health Improvement activity

3.1 The CMO's report highlights the cost effectiveness of health improvement activity in relation particularly to alcohol, smoking and obesity. These are all areas which have been supported by Scottish Government targets and direct funding and where we believe that further progress could be made with continued and extended commitment at national level. The main areas for focus would be:
- Alcohol. Continuing programmes of brief interventions, supported by national and Local Authority action on pricing and availability
- Smoking. Expansion of evidence based supported smoking cessation programmes, including focus on smoking in pregnancy which could release real savings in the short term in relation to low birth weight babies.
- Healthy weight. Continuation and expansion of child and family health weight programmes in conjunction with schools and nurseries.
- Anticipatory care programmes, as a means of identifying risk and ensuring that individuals participate in the above supports.

3.2 Whilst there are significant direct costs to health services associated with these issues, and therefore savings to health services from prevention activities, there are also wider potential savings relating to social care, criminal justice (particularly in relation to alcohol), productive capacity and wider social costs. Therefore the issues above about where and when savings accrue and how funding can be released to support prevention also apply to some extent.

3.3 These are all areas where indicators and targets are already in place.

4. Reshaping Care for Older People

4.1 The call for evidence specifically focuses on early years. However, we also want to highlight the role of preventative spend in supporting the objectives of Reshaping Care for Older People. Specifically, we hope to see continuation of the Change Fund money beyond the initial one year allocation to support redesign and shift away from hospital and care home provision.

4.2 However, this needs to be supported by a clear accountability structure to ensure that change fund money does not substitute for cuts in existing service provision and that there is a genuine reduction in demand for hospital services. A set of national indicators for the change fund has already been agreed. In our view, the most significant indicator in the short term is the total number of bed days lost to delayed discharges.
4.3 As discussed in section 2 above, we also believe that a clearly defined model of health and social care integration with single accountability for services and budgets would greatly support the delivery of effective services for older people.

5. Conclusion

We welcome the opportunity to respond to this call for evidence and would be happy to provide further information.

NHS Greater Glasgow and Clyde
September 2011
Appendix 1: Summary of prevention activity

<table>
<thead>
<tr>
<th>Issues</th>
<th>Impact on public spending</th>
<th>Effective interventions</th>
<th>Government support required</th>
<th>Indicators</th>
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<tbody>
<tr>
<td>Early years support and early intervention</td>
<td>High ‘failure’ costs for individuals and public bodies, including direct costs to social care, criminal justice and welfare / benefits, wider society costs and long term impacts on health.</td>
<td>Family support Tiered parenting support High quality early years childcare Antenatal support</td>
<td>Increased resource to NHS universal services to assess risk and direct supports. Clear model of integration. Support for financial modeling and budgetary mechanisms to manage resource shifts across agencies and different timescales. Clear requirement for progress on indicators</td>
<td>- developmental measures (including language) as identified at the 30 month assessment. - readiness for school - low birth weight and early access to antenatal care. - high quality nursery places. - immunisation uptake.</td>
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<tr>
<td>Healthy Weight</td>
<td>Total economic impact of obesity within Scotland was estimated at £457 million in 2007/8 including direct NHS</td>
<td>- combined approach of school based interventions and Intensive community based interventions - Ongoing support and commitment</td>
<td>- National funding confirmation beyond March 2012 (£427,116 allocated 2011/12) Supporting continued</td>
<td>HEAT targets</td>
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<tr>
<td>Smoking</td>
<td>Direct costs to NHS alone estimated at over £300m per annum</td>
<td>Group support</td>
<td>Support to continue and extend smoking cessation programmes</td>
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<td></td>
<td></td>
<td>Brief interventions</td>
<td>Continued review of legislative measures re availability, packaging and advertising</td>
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<td></td>
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<td>Behavioural support combined with pharmacotherapy</td>
<td>Smoking prevalence Smoking cessation</td>
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<td>Support for smoking cessation in pregnancy</td>
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<td>Alcohol</td>
<td>Total cost estimated at over £3bn per annum including health care, social care, crime, productive capacity and wider social costs</td>
<td>Brief interventions</td>
<td>Legislation on minimum pricing and availability</td>
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<td></td>
<td></td>
<td>Access to treatment services</td>
<td>Consumption Alcohol related deaths Portland Alcohol related admissions</td>
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<td></td>
<td>costs and indirect costs associated with inactivity, worklessness etc. The total costs generated by childhood obesity accumulate over the entire lifecourse.</td>
<td>to the programme by local Education Departments and Head Teachers</td>
<td>multi agency approaches across Health, Education, Leisure services etc</td>
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<td>Continued joint delivery with Local Authority Leisure Providers</td>
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<td>Extending lessons from pilot programmes, e.g. Big Eat In</td>
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Appendix 2

MIND THE GAPS: IMPROVING SERVICES FOR VULNERABLE CHILDREN

1. PURPOSE

1.1 The recent HMIE child protection report identified serious issues in the provision of services for vulnerable children and families. The joint group established to develop a response to the HMIE report commissioned this paper to provide a basis for agreeing how to address these issues. This paper seeks to outline the context of vulnerability in Glasgow, describes the impacts of vulnerability on children, society and services, explores the evidence-base for responses to reduce the impact, and proposes action.

1.2 The HMIE child protection report noted positive services, but it judged services to be weak in the planning and delivery of interventions to support vulnerable children whose risk factors were below the threshold for ongoing statutory child protection support, or for those children whose circumstances had improved sufficiently to be removed from formal child protection arrangements (HM Inspectorate of Education, 2009).

1.3 Services to protect vulnerable children are at the top of the public and political agenda. Recent criminal cases within Scotland and throughout the UK have demonstrated the high standards the public expects from services in this regard. Serious case reviews consistently cite unmet need as a causal factor in significant child protection failures.

1.4 There is a consensus within both health and social care staff that the thresholds for intervention within vulnerable children and families are too high. While this paper identifies opportunities to reshape the use of our current resources, these high thresholds are directly related to the levels of resource relative to the scale of need within Glasgow. Concerns about high thresholds and inadequate support for intervention are echoed within the HMIE report.

1.5 To achieve a shift in thresholds will require substantial additional resources, over a sustained period. Unmet need will not be addressed through simply driving improvement and efficiency, although that drive must be a parallel activity to investment and development. The two must not be regarded as choices or as mutually exclusive.

1.6 As a result of inadequate resources and excess need, attention and effort are inevitably directed towards the immediate protection of children at very high risk. This unavoidable service response reduces the capacity to deliver the most effective response to children’s problems: early intervention. This paper outlines the rationale and evidence for early intervention.

1.7 As a result of our limited ability to intervene within children’s lives at an early stage, responses usually occur when children have suffered developmental consequences. At that point responses are more costly and less effective than earlier interventions would be. The consequences
of limited and late intervention include educational failure, anti social behaviour, crime and violence, and responding to these problems consumes increasing sums of public money. The most effective interventions to improve the lives and opportunities of vulnerable children will be delivered before they are three years old.

1.8 The message this paper carries about resources is a tough one in the present economic climate. However, it is a matter of fact that a recession will increase and intensify the scale of need and the consequences of failing to meet it, both for vulnerable children and for the wider communities of Glasgow City.

2. CONTEXT

2.1 This paper defines vulnerability as factors which increase the likelihood of a given child being subject to abuse of any form. Vulnerability factors can affect parents themselves, the socio-economic environment the child is living in, the family structure or the may be specific to the child themselves.

- parental risk factors: young parental age; poor education; parents abused as children; psychiatric problems; and substance abuse;
- socio-economic risks: poverty;
- family risks: single parents; step-parents; larger families; and domestic violence;
- child-related risks: premature birth; poor health; and disability.

The most significant risk factor is that of poverty. The UK-based ALSPAC study, based in Bristol reported the strongest risk factor for child abuse was that of poverty, which increased the risk of child abuse by more than 11 times (Sidebotham and Heron, 2006).

2.2 Indicators of vulnerability include:

- 1 in 3 children within Glasgow City Council area live within workless households in comparison with 1 in 5 nationally;
- 64% of Glaswegian children live within low-income families (Walsh, 2008);
- around 38% of children live in poverty, one of the highest rates in the UK;
- of Glasgow women giving birth around 58% live in the most deprived circumstances;
- substance misuse affects around 20,000 children in Glasgow;
- around 10,000 children are known to social work but only 300 are in formal child protection procedures;
- the City has 20%, or 3000, of Scotland’s looked after children;
- 50% of Glasgow’s children have significant educational challenges, and this results in around 25% of Glaswegian children attaining at least 5 SCVQ qualifications in S4, compared with 35% nationally.
Using Health Plan Indicator data, almost 17,000 families resident within Glasgow City were classified as vulnerable, and in need of additional support from services (NHSGGC Health Visitor Workforce Review, 2008).

3. IMPACTS AND POTENTIAL RESPONSES

3.1 Whilst child abuse can take a number of forms, the commonest in Glasgow is parental neglect. This is linked to poverty, poor parenting, and significant levels of substance abuse. Children who are neglected suffer profound developmental consequences which affect their potential, create a significant drain on future public resources, and reduce their future contribution to society. Furthermore, without supportive intervention, the next generation are more likely to develop similar needs.

3.2 The biological, developmental and psychological impacts of vulnerability factors experienced in children on their later physical and psychological health is an area of active research. The slide below (Figure 1) illustrates the physiological impact of neglect. The brain of an extremely neglected child aged three is already significantly damaged. Early stress can have a profound effect not only on the structure of the brain, but on the way it functions. McEwan has shown that long term stress during early development affects memory and reasoning. Early intervention in cases of neglect can allow a child to recover developmentally, and reduces the impact of the neglect on their future potential. Moreover, the ability of a vulnerable child to benefit from interventions is greater in early life.

Figure 1: CT scan comparing the brain of a 3 year old child affected by neglect with a normal child aged 3.
3.3 Children who experience abuse are far more likely to develop behavioural and psychological problems, and to become involved in the criminal justice system than their counterparts who do not suffer abuse. The relationship is strongest for those experiencing sexual abuse, but around a third of neglected children exhibit symptoms including difficulties with anger containment, physical aggression, threatening behaviour towards others, use of weapons, cruelty towards animals, vandalism and fire-setting. This link between abuse and future behaviour is strong, with a large proportion meeting the criteria for conduct disorder or other psychological problems within adult life.

3.4 The consequences of conduct disorder on society are significant, with violent behaviour increasing the use of health, social care and justice systems, as well as having an impact on the wellbeing and prosperity of others. In addition, conduct disorder reduces the ability of affected individuals to be financially self-sufficient. Crime is one of the most significant costs of failure to intervene, imposing additional costs of up to £60 billion per year on society. Figure 2 illustrates the total extra cost to age 28 of a child developing a conduct disorder.

![Figure 2: 1998 Societal costs of a child with no problems, conduct problems and a diagnosed conduct disorder.](image)

3.5 Children with persistent antisocial behaviour aged 10 cost society ten times as much as children without the disorder by age 28. The consequences of vulnerability in childhood are increased costs of health, social care and education in childhood, and in adult life, increased costs of crime and disorder, substance misuse, worklessness and intergenerational poverty, with all the financial consequences on health and social care which this entails.
3.6 Poor parenting has immediate and longer-term impacts on the child:

<table>
<thead>
<tr>
<th>Immediate Impact</th>
<th>Long Term Impact</th>
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<tbody>
<tr>
<td>- Feel emotionally excluded</td>
<td>- Low attachment to family, school</td>
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<tr>
<td>- Don’t learn social skills</td>
<td>- No ‘good’ friends, fail in love</td>
</tr>
<tr>
<td>- Feel stupid and incompetent</td>
<td>- Poor confidence, touchy</td>
</tr>
<tr>
<td>- Little persistence</td>
<td>- Low qualifications, poor work</td>
</tr>
<tr>
<td>- Feel frustrated and angry</td>
<td>- Antisocial, criminal, drug misuse</td>
</tr>
</tbody>
</table>

3.7 For vulnerable children, their progression from infancy towards adulthood is marked by a series of lifecourse stressors, which pose actual risks to them as children, and endanger their ability to reach their full potential as productive members of society. However, we also know that there are supportive interventions at the level of society and targeted towards vulnerable families which can reduce the impact of these risks (Shonkoff J and Phillips D, 2000), see Figure 3.

Figure 3: Stressors and protective factors operating along the developmental pathway towards adulthood.
3.8 The outcomes from early intervention are achieved across a number of different agencies, but include: reduced use of health and social care services; reduced contact with criminal justice; improved personal income and home ownership; and improved profiles for risk taking behaviours around smoking, alcohol and numbers of sexual partners.

3.9 Economic evaluations of the rate of ‘return’ from investment in interventions at different stages of child and adolescent development has concluded that the maximum impact is obtained by intervening in the preschool and early primary school stages (Carneiro and Heckman, 2003). See Figure 4.

3.10 The population-based intervention using the Triple P Programme (Positive Parenting Programme), which aims to use an incremental model to improve parents’ capacities to provide appropriate parental support for their children, and to tackle early signs of problematic behaviour in a positive manner. Other countries have implemented such programmes, and Triple P, delivered via health and social care professionals working in concert with the Parenting Co-ordinators appointed in each CHCP have the capacity to effect change in family environments which will reduce antisocial behaviour, with reductions in the demands on health, care and justice systems.

3.11 The conclusion reached by examining a number of different lines of evidence is that early interventions represent the most cost-effective solution for tackling the intergenerational effects of poverty within vulnerable families. The analysis also demonstrates that the impact of failing to intervene is profound: significantly increased costs throughout childhood and adult life and a high risk of the next generation having the same problems, the intergenerational transmission of poverty.
Figure 4: Schematic showing the economic analysis of returns from investment in family and educational interventions across the lifecourse of children. The returns are greatest with the earliest interventions and greatly exceed the return from alternative uses of the same resources up to the mid point of schooling (opportunity cost). Adapted from Carneiro and Heckman, 2003.

4. WHAT SHOULD HAPPEN IN GLASGOW

4.1 Section A of this paper emphasised that to break the cycle we are in, where we do not meet the needs of the vulnerable children, we need a sustained, comprehensive, coherent programme of development and investment with strong political leadership and full commitment, most particularly from the Council and the NHS, but with the essential support of the Police, the Reporters administration and the Voluntary sector.

4.2 Glasgow also needs to respond positively to the HMIE report. We are proposing a number of elements of response for consideration. These are:

- building on the existing commitments to implement the parenting strategy;
- developing family support services;
- providing nursery placements for babies and infants under 3;
- moving to a stronger and more systematic culture of early intervention.

4.3 This section outlines in more detail the proposed actions in these four areas, which taken together will represent a step change in the outcomes
we can achieve for these children and concludes by setting out an approach to assessing progress.

4.4 Parenting

4.4.1 Glasgow’s recently agreed Parenting Framework represents an evidence-based approach to tackling vulnerability at the level of the population. Given Glasgow’s very high levels of vulnerability, such an intervention should be prioritised, and we would argue that it should receive recurrent and increasing funding to facilitate its objectives, subject to its successful evaluation.

4.4.2 The Children’s Services Executive Group has identified parenting support as a key driver to improve educational, social and health outcomes in Glasgow’s children. The central model to support parenting must be Triple P (Positive Parenting Programme) (Sanders RS et al, 2003), as only this programme offers a range of universal and more intensive, specific interventions to meet the needs of Glasgow’s population.

4.4.3 Delivering support for parenting will require a number of changes across children’s services, and the focus on parenting and parenting interventions must be a visible priority for all staff groups in these services. Implementing the Parenting Framework will require both strong leadership, multi-agency commitment and the support of front-line staff if it is to deliver the improved outcomes seen internationally.

4.4.4 A focus on support for parenting provides a coherent link between all the services supporting children and families in Glasgow. Additional interventions such as multi-systemic therapies; functional family therapy; home-based treatment; and treatment foster-care all have robust evidence-bases and are coherent with the overall parenting framework and Triple P. This group of parenting interventions has the potential to deliver real changes in the educational, social and health outcomes of Glasgow’s children, and will require all agencies to collaborate to ensure that they are embedded within the children and families framework.

4.5 Family Support

4.5.1 There are a number of elements of analysis and work in relation to family support services. In terms of making the best use of current resources, health and social care staff operating within level 1 and 2 services can be considered as three broad groupings: upper grade professionals (health visitors and social workers); intermediate grades such as staff nurses; and lower skill workers such as home-support staff. Extending work redesign across health and social care staff could result in three broad grades of staff across operating at levels 1 and 2. This approach could provide ways of enhancing social work capacity to address the very high levels of need found in Glasgow.
4.5.2 GCC is currently auditing the numbers, location and employment status (directly employed or contracted) of staff in support roles. These resources could be realigned to focus these staff. Staff could be moved to support vulnerable families, or cost-savings which may occur from this review could be reinvested within family-support.

4.5.3 The Health Visitor Review analysed the support workforce indicating that only one support worker was in place for every 206 vulnerable families. This ratio is too low given the level of need and it is proposed that the ratio should incrementally shift to one worker per 30 families – based on an assessment of both the work of David Olds from the US using nurses, and experience from the local implementation of Starting Well, which used staff analogous to band 3/4.

4.5.4 This approach would require additional band 3/4 employees embedded within children’s and families teams, operating in a co-ordinated manner. The estimated additional costs to meet this level of family support are shown in Table 1.

<table>
<thead>
<tr>
<th>Year</th>
<th>No of support staff</th>
<th>Annual additional cost</th>
<th>Ratio of staff to vulnerable families</th>
</tr>
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<tbody>
<tr>
<td>2009/10</td>
<td>86 posts (81 existing*)</td>
<td>£1.9M</td>
<td>1 to 100</td>
</tr>
<tr>
<td>2010/11</td>
<td>253 (plus 81*)</td>
<td>£5.5M</td>
<td>1 to 50</td>
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<tr>
<td>2011/12</td>
<td>477 (plus 81*)</td>
<td>£10.4M</td>
<td>1 to 30</td>
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4.5.5 Notwithstanding the potential for reshaping existing staffing, significant new investment will be required to address the deficit in family support staff. These staff would represent a solution to HMIE’S direct criticism of risk management for vulnerable children and families below the threshold for formal child protection registration.

4.6 Nursery Services

4.6.1 Developing nursery services demonstrates the significant benefits flowing from investment in this activity. Government policy has seen the introduction of universal nursery provision for 3 and 4 year olds. There are
also pilots of nursery placements for vulnerable children aged 2 in Glasgow, however there is limited provision of nursery services for vulnerable babies and infants aged 0-2 outwith formal child protection requirements. Such nursery placements provide protected and stimulating learning environments for vulnerable infants, and provide support for vulnerable parents struggling to cope with their children.

4.6.2 Glasgow’s under 3 population has been estimated at 20,300 children in 2008. Around half of these children have vulnerability factors and the majority live within the 16,742 families identified as vulnerable through the Health Plan Indicators. What proportion of children within these families would benefit from childcare placements is not entirely clear but it is safe to assume it will be a high proportion. Subject to further work to establish the scale of need in this group, it is likely that any development will require substantial additional funding.

4.6.3 In the light of the evidence, it is suggested that additional capacity should be created to provide nursery placements for babies and infants under the age of 3 throughout Glasgow.

4.7 Early Intervention

4.7.1 All staff in health and social care must develop a focus on the early identification of, and support for vulnerability. While families without vulnerability factors can negotiate and access the array of services provided across the organisations, this is not the case for vulnerable families, who often exist at the margins, have low levels of support, and are often characterised by chaotic lifestyles. For vulnerable families, coordination, contact, ongoing evaluation of the impact of interventions, and support are critical. Whilst family support staff can provide general support and can attend to some of these needs, such as advocacy and coordination of services, more highly skilled staff will need to adapt and provide ongoing evaluation of the impact of their interventions.

4.7.2 Simply providing further support staff without a change in the culture of working will not achieve the full impact. The purpose of redesign is to facilitate cultural change. Therefore, additional expenditure must be tied to ongoing redesign of services. The culture of work within the children and families teams must change, and must be centred on the needs of vulnerable children and their families. This will require all staff, but particularly the family support staff to develop styles of working which foster relationships with vulnerable children and their families.

4.7.3 There is also scope for redesign within the specialised services provided by both health and social care. This activity needs to ensure that costly interventions such as residential units can be replaced by safe and effective alternatives, where that is appropriate.

4.7.4 The evidence suggests that vulnerability can be identified either prenatally, or in the early postnatal period. Clearly this would be advantageous, as interventions and support could start almost immediately. Whilst midwives
and health visitors provide a universal contact, and are the key group for identifying vulnerability factors, additional approaches including the provision of new mums groups in localities might represent a method of providing support more informally. It is recommended that approaches to enhance pathways for vulnerability should focus on vulnerable women from the antenatal period. Given the scale of vulnerability in Glasgow, the launch of the parenting framework and any plans to introduce family support services must take account of the need to raise awareness of vulnerability across all staff groups. All staff must develop a focus on the early identification of vulnerability, and recognise the additional practices which are needed to help this group. Given the value of early intervention, methods of identifying vulnerability, particularly in new first time mums should be developed in each CH(C)P.

4.8 Assessing Progress

4.8.1 Vulnerability is a complex issue, with some families having a number of different risk factors, and with vulnerable children and their families coming into regular episodic contact with almost all agencies. Serious case reviews regularly point out the number of missed opportunities to intervene in the lifecourse of a child. However, how these children’s contacts with services compare with those of the general population is unknown. There is a need to build on partnerships in the children’s analytic network to develop linked multiagency work addressing this area. Scotland’s public services have excellent information systems, and the capacity to anonymise and link data across agencies to explore the relationships between the use of services and outcomes needs high-level interagency agreement. The Children’s Analytic Network should be tasked with developing proposals to analyse the contacts of vulnerable children with health, social care and justice services in comparison with the contact rates of the non-vulnerable population. This work will require the linkage of data across services. In addition, a group should be convened to set a small number of indicators to guide progress on developing services addressing vulnerability.

5. CONCLUSIONS

5.1 Significant numbers of Glasgow’s children are vulnerable, largely as a result of poverty and substance abuse. Early intervention will enable them to reach their full potential, and will break the intergenerational cycle of poverty.

5.2 There have been many discussions within community planning about creating a cross cutting focus on vulnerable children, and it is Fairer Scotland funding which offers the most appropriate and accessible source of substantial new resources. We would argue that there is merit in
reprioritising Fairer Scotland funding to focus more on addressing the causes of social problems and less on dealing with their consequences.

5.3 New funding is already agreed, through additional resources for addiction focused on children affected. However, we propose that in order to make an immediate and visible commitment to address these challenges, £5M of Fairer Scotland funding should be earmarked to underwrite the proposed developments during the current financial year (allowing for estimates around the funding of additional nursery places for vulnerable under 3s), and that this allocation should rise to £10M in 2010/11 and £15M in 2011/12. In the longer term it is clear that the focus on early years will require a fundamental reprioritisation across the city to see all organisations refocusing their budgets on these services.

C M Renfrew
L de Caestecker
JJM O’Dowd
21 May, 2009

References


