

## Editorials

# Primary care of children: the unique role of GPs



### THE ROLE OF BRITISH GPs IN CARING FOR CHILDREN IS UNDER THREAT

The provision of medical care for children and young people is changing. Access to GPs has reduced since 2004 due to changes in out-of-hours care. In-hours, the Quality and Outcomes Framework (QOF) has shifted priorities away from providing care for children. Few childhood conditions fall inside the QOF, and consultation rates have increased for all age groups except children.<sup>1</sup>

Most parents prefer to see their own GP but accept that out of hours this may no longer be possible. Yet out-of-hours services are no substitute for GP care, often directing parents to seek several consultations for the same problem,<sup>2</sup> costing families time, money, and increasing anxiety, and potentially introducing delay in diagnosing and treating serious illness. This has impacted on paediatric services in hospital accident and emergency departments which are already stretched and under pressure to achieve waiting time targets, resulting in increased inappropriate short stays in hospital.

One in four children aged under 18 years (3 million) attend emergency departments each year;<sup>3</sup> short stay admissions (less than 48 hours) have increased by over 40% in a decade.<sup>4</sup> At the same time acute paediatrics is changing very fast, with the emergence of Paediatric Assessment Units, a new model for paediatric community services open for 18–24 hours, potentially almost completely replacing the GP role as the front end of paediatric out-of-hours emergency care.<sup>5</sup>

The health of British children compares less favourably than many in Europe. All-cause mortality in UK children under

5 years of age is worse than Sweden, France, Italy, Germany, the Netherlands, and other developed countries in Europe, especially for primary-care sensitive conditions such as asthma, meningococcal disease, and pneumonia.<sup>6</sup> One in three British children is overweight and 15% are obese, risking serious cardiometabolic problems in adulthood. We have the highest teenage pregnancy rates in Europe. The Royal College of Paediatrics and Child Health has suggested that we should move to a more North American/continental model, where most paediatric primary care is provided by trained paediatricians.<sup>5,7</sup> But is this really the best model for the UK?

### THE POTENTIAL FOR GENERAL PRACTICE-LED PRIMARY CARE PAEDIATRICS

This month's child-health themed Journal outlines what needs to be done to improve child health from within primary care. Dervla Kelly and colleagues report that folic acid supplementation during the first 12 weeks of pregnancy is beneficial for reducing cleft lip and palate, as well as neural tube defects, reminding us that GPs are the single best placed health professionals to build a rapport with expectant mothers.<sup>8</sup>

We can provide support throughout the pregnancy and postnatal period; assist new mothers to negotiate transitions into parenthood, convincing them of the benefits of vaccinating their child, and helping them to cope with acute childhood illness. At present 98% of the nation's children are registered with an NHS GP, and we still see them three to six times per year into adulthood. Each consultation is an opportunity to provide education and support to help parents cope and develop their skills in managing their child's illness.

GPs are ideally placed to identify the psychosocial and physical problems that cluster within families, but sometimes miss opportunities for intervention. Potter *et al* report that nearly a quarter of children who have a depressed parent themselves met the criteria for a mental health disorder and nearly two-thirds of these were not in contact with health or social care.<sup>9</sup> Woodman *et al*'s paper highlights that GPs are not good at recording concerns about possible child maltreatment in children's electronic medical record, and suggests a simple and feasible approach to help improve our systems for caring for vulnerable children.<sup>10</sup>

Two papers give a snapshot of the challenges GPs face daily in dealing with children. Ahrensburg *et al* report on the challenges involved in diagnosing cancer in children, with most early symptoms being general and non-specific.<sup>11</sup> Nevertheless, 80% of children had at least some primary care involvement in their diagnosis. But of course, serious conditions in children, such as childhood cancer, are rare and Brett *et al* point out that most cases of abdominal pain in children have no underlying organic pathology.<sup>12</sup> This highlights the challenge of diagnostic uncertainty in balancing the risks of over-investigation and referral against the possible delay in a serious diagnosis.

### HOW CAN WE IMPROVE WHAT WE DO TO BENEFIT CHILDREN?

Prevention and education are our staples including tailored health messages for children and families and reinforcing the importance of vaccination. We should aim for a level of accessibility and responsiveness that fits in with the needs of parents of children with acute illness. We need to improve our recording and alerting

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systems not only for better continuity for individual children, but also across families, and to achieve better communication and integration of services across the primary care team including health and social care professionals.

Key among these challenges is the sufficiency of general practice training in paediatrics. We need to improve our knowledge base and skills in diagnosis and management of less common childhood conditions. GP trainees typically get around 6 months' exposure to paediatrics (16% of clinical training), but half of this time is spent in specialist neonatal units; yet children and young people under 18 years account for 26% of all GP consultations.<sup>1</sup> Although there has been a move to develop GPs with a special interest in paediatrics within each practice, this has not been taken up with the enthusiasm of other specialists in general practice. However, the Royal College of General Practitioners has just received approval to extend GP training and this will provide an important opportunity to redress the balance and ensure that the proportion of GP training spent on paediatrics is proportional to the amount of time GPs spend dealing with paediatric patients.

Clinical commissioning groups in England may bring new opportunities for better integration between paediatricians and GPs, reducing inappropriate referrals and drive down unnecessary accident and emergency attendance and hospital admission rates. One possible mechanism is for educational outreach with local paediatricians holding in-practice ward rounds where the needs of children and families are discussed, linking local acute hospital paediatric assessment units directly to primary care. Improving health education for families could play an important role in improving child health and reducing unnecessary consultations. We should look to the Swedish model of primary-care-based child health clinics for this. The revised models of GP care should hold family medicine at their core and adapt to include, not exclude, children.

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The authors have declared no competing interests.

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