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Sure Start in England

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Sure Start in England

Abstract

In her Comment (Nov 8, p 1610) on our second phase of evaluation of Sure Start local programmes in England, Penny Kane makes several points with which we could not agree more. Like her, we would have much preferred to see a randomised controlled trial done, since this would have afforded much stronger causal inferences than the quasi-experimental investigation we undertook. We also agree that the fact that we drew on data collected by two different research teams raises questions about the confidence that can be placed in conclusions drawn.

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safety of the tested drugs were not different between patients with and without diabetes. We recorded the glycaemic and glycosylated haemoglobin values at baseline and during the 3·9 years of average follow-up. As for glitazones, their use is not extensive in Italy, but we did not specifically record this treatment.

Christopher Florkowski and colleagues again bring up the hypothesis that a reduction in coenzyme Q10 induced by statins might mask the potential benefits of these drugs in patients with heart failure. Actually the Q10 argument was usually a safety concern, yet rosuvastatin seemed to be safe in GISSI-HF as well as in the CORONA trial.[3] As for efficacy, although the possibility that a potential benefit from statins might be concealed by a decrease in Q10 production cannot be ruled out, the perspective of admistering two drugs, one to counteract the negative effect of the other, to elderly patients with heart failure, who are probably already on multiple drugs, does not seem too promising.

Vincenzo Solfrizzi and coauthors seem to consider the GISSI-HF populations too heterogeneous, with frail elderly patients being over-represented. However, in the GISSI-HF population, two-thirds were of New York Heart Association (NYHA) class II and the remaining third were class III patients with a mean age of 67 years (the median age of patients with chronic heart failure being around 75 years). Accordingly, the criticism looks unfounded.

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In her Comment (Nov 8, p 1610)[1] on our second phase of evaluation of Sure Start local programmes in England,[2] Penny Kane makes several points with which we could not agree more. Like her, we would have much preferred to see a randomised controlled trial done, since this would have afforded much stronger causal inferences than the quasi-experimental investigation we undertook. We also agree that the fact that we drew on data collected by two different research teams raises questions about the confidence that can be placed in conclusions drawn. Indeed, these were points we made in our original report.

We remain agnostic as to whether the positive effects of Sure Start local programmes we detected were insufficient to be of policy importance or should have emerged on other child outcomes such as verbal ability, especially in so short a time frame (ie, when children are 3 years old). Open-minded scholars can have honest disagreements on this issue.

We are continuing to follow up the children and families to determine whether, at age 5 years, the effects detected at age 3 years have been maintained, dissipated, or changed in some manner. We look forward to reporting on this matter in the not-too-distant future.

We declare that we have no conflict of interest.

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The UK's system of general practice, based on the long-term registered population, is one of the most popular, successful, and efficient ways of delivering primary health care. It allows for continuity of care, a multidisciplinary approach, and a systematic integration of individual and family acute health care with risk management, preventive interventions, and care of long-term disorders. How tragic that the potential of this horizontal approach, so often shown to be successful, has been ignored by the vertical approach in relation to health care embodied in children's centres and the Sure Start programme.

I work in a large general-practice team that includes doctors, nurses, and child health visitors, in a health centre owned by the National Health Service. I walked 200 m down the street to discover a children's centre under construction, of which none of us was aware. Although the additional support for families and children from psychology to baby massage is very welcome, it is no surprise that this separate programme is associated with lower child immunisation rates.[1,2] Immunisation normally takes place in general practice, where Sure Start has no structural input.

This has been a missed opportunity for strengthening children's services through horizontal integration of social services with primary health care, and is ironic at a time when the UK government has been promoting polyclinics in the community. Development is always needed. I hope it is not too late to grow together.

I declare that I have no conflict of interest.

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