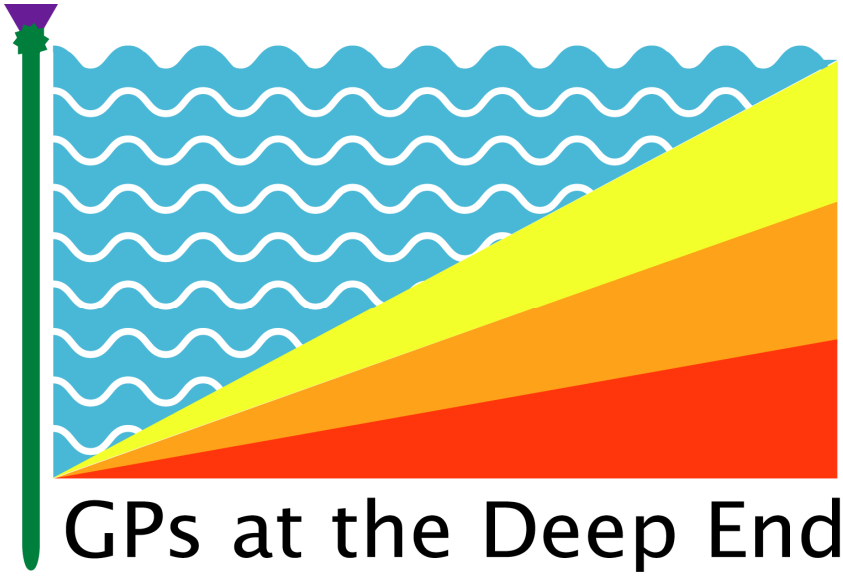

Deep End Report 3

The GP role in working with vulnerable families

The third meeting of "General Practitioners at the Deep End"

22 January 2010

Ten Glasgow GPs met on Friday 22 January 2010 at the University of Glasgow for a workshop on the contribution of general practice on deprived areas to the care of vulnerable families.

SUMMARY

- Working with vulnerable families is an everyday aspect of general practice in severely deprived areas.
- Through many types of contact, practice teams have substantial knowledge about the most vulnerable families in their registered population. Several recent NHS developments have under-mined this knowledge.
- General practices offer constant, accessible, informal and unconditional contact and support (irrespective of age), referral to other services when necessary, and continuing support when other services cannot respond.
- The case-finding approach in general practice appears an insufficiently valued mechanism for matching need to service provision and preventing, delaying or ameliorating more serious problems
- The withdrawal of child surveillance in deprived areas is considered a mistake, given the high yield of health and social problems.
- The current "rationalisation" of health visiting appears to devalue the importance of shared knowledge, continuity, relationships and trust, concerning the wider "at risk" population of vulnerable families.
- Practices should have effective ways of regularly sharing information about vulnerable families; they need regular updates concerning the availability of other local services; they also need improved working relationships with social work and the school health service, based on personal continuing contact with individual social workers and school health nurses.
- Practices should identify their lead professional for vulnerable families, co-ordinating activities within their practice and considering the ways in which they could work more effectively with other practices and other agencies.
- It is important for the system to take account of the views and experience of families using services.
- There is a need for more effective and quicker dialogue between practices providing front-line services and those responsible for local and national policy on child welfare and vulnerable families.

GPs at the Deep End

"General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.*

Contacts for further information

Paul Alexander *RCGP Scotland* palexander@rcgp-scotland.org.uk
John Budd *Lothian Deprivation Interest Group* John.Budd@lothian.scot.nhs.uk
Petra Sambale *Keppoch Medical Practice, Glasgow* psambale@btinternet.com
Graham Watt *University of Glasgow* graham.watt@glasgow.ac.uk

CONTENTS

ATTENDING

Name	Location	Practice deprivation ranking
Wilma Best	Gorbals Health Centre, Glasgow	54
Albert Burton	Woodside Health Centre, Glasgow	51
Rosalind Hoplin	Tollcross Health Centre, Glasgow	86
Clare McCorkindale	Kelso Street Surgery, Glasgow	67
Kerry Milligan	Glasgow Homeless Practice	n/a
Yasin Mohammed	Westmuir Medical Centre, Glasgow	20
Anne Mullin	Govan Health Centre, Glasgow	80
Anna Pettigrew	Springburn Health Centre, Glasgow	45
Sandra Spilg	Pollokshaws Medical Centre, Glasgow	88
Graham Watt	University of Glasgow (Rapporteur)	n/a
Alan Winter	Edinburgh Road Practice, Glasgow	62

AIMS

This meeting aimed to:

- Capture examples of how GPs make a difference, engaging with vulnerable families based on first-hand accounts.
- Discuss where GPs see themselves fitting into issues of child welfare –a broad umbrella for child protection, child safeguarding, child well-being. These all have fuzzy definitional edges but are conceptually linked through various political and policy frameworks.
- Consider the requirements of general practice as a frontline service for many vulnerable families.
- Outline what this service would look like if we were afforded more resource and able to influence the development of service provision.

REFLECTION

The group felt that this is an everyday aspect of their work and more common, for example, than cancer. It was noted that 65% of the children on the Glasgow child protection register are registered with the 85 Glasgow general practices in the top 100.

It was noted that the incentives of the new GMS contract provide no support for practices to take an interest in this area. GP involvement is driven by a pragmatic, conscientious and professional response to the needs of patients.

What makes a family "vulnerable" is difficult to define precisely, but is usually obvious in practice. Poverty and addiction in a family member is often the cause, with consequences which affect other members of the family. This wider view is often available to the practice team when everyone in the family is registered with the practice, and may be missing when a key individual is registered elsewhere and is not known to the practice team.

A general descriptor would include families with chaotic lifestyles and financial problems. Homeless families and people recently discharged from prison can be particularly vulnerable. Although such factors often compromise the health and development of children, the group knew of many children who had nevertheless developed successfully.

This broad definition encompasses all age groups and is not confined to the arbitrary criteria which determine access to other services, such as social work (mainly concerned with children under 5) and child and adolescent psychiatry (whose services are restricted to the most severe cases of self-harm). It was noted that very few agencies are available to help families with behavioural problems, and that the current scale of this problem has outstripped the ability of services to deal with it. In the medium to long term, it is hoped that the Health Board's parenting strategy, employing the Triple P programme, will help to reduce the scale of the problem.

The knowledge of a practice team about families on their list comes not only from contacts with families when they are in deep distress, but also from routine contacts, including routine consultations with general practitioners and nurses, and preventive activities targeted at all children (such as immunisation and child surveillance). Practice receptionists are also a valuable source of information and concern.

The role of health visitors in monitoring all children within a practice has been a valuable type of contact with vulnerable families, providing information about current and potential problems, and increasing vulnerable families' participation in preventive activities such as immunisation.

From these many contacts, the practice team is well placed to identify families in which there are current problems and/or reasonable concern about the probability of future problems. It was recognised that such information is almost always partial, and that health professional's knowledge of families is determined by what families wish them to know.

This knowledge of a practice is largely built up by informal means, based on contacts which are built up over time. Although there are systematic aspects, such as immunisation (and until recently, child surveillance), the approach is largely

informal, inevitably incomplete, but pragmatically effective in knowing about the most vulnerable families on a practice list. No other part of the system holds such knowledge.

To make best use of this information, practices must have regular and effective ways of sharing information within the practice team. The group heard how regular monthly meetings of practice staff can provide a focus for considering the most urgent problems. Some GPs had experience of attached addiction workers and social workers (although not recently), which had worked well in sharing information, and helping families and professionals to break out of repetitive cycles of behaviour.

The extent of a practice's knowledge about families with young children has been reduced in recent years as a result of policy changes, such as the increasing role of community midwives in antenatal care and the withdrawal of formal child surveillance programmes. The focusing of health visiting on a minority of high risk cases will also reduce the breadth of contact with the practice population.

The group felt that the withdrawal of routine child surveillance had been a mistake, and had given insufficient consideration to the high yield of such programmes in deprived areas, in terms of the number of health and social problems ascertained within families. The narrow evaluation of such schemes (in terms of screening for particular clinical conditions) had under-valued their general preventive value.

The group felt that greater value should be placed on the importance of continuity and retention of staff within local areas. Relationships and knowledge take time to build up. Even experienced health visitors need a significant amount of time to become maximally effective in a new setting. Recent proposals for re-distributing health visitors, as a "movable and manageable resource" give scant regard to this aspect of their work.

The basic service which practice teams offer vulnerable families is unconditional contact, support and continuity, with referral to other services when appropriate and possible. The accessibility and informality of such contact is considered extremely important, and may be the only source of help and advice that a family has.

Referral is compromised when the full range of available local services is not known to the practice team, which may be the case when new services are introduced and old ones discontinued. The group considered that it should be possible for such information to be provided on a continuing, updated and accurate basis. In practice, such communication is often by word of mouth as colleagues and families share experience and information.

Referral is also limited by the lack of resource within sought services, whether to social work or child and adolescent psychiatry. With long waiting times, families and practices are left in limbo. Although practices may be limited in the material support they can provide, the group considered that continuing informal support and accessibility can be crucial in helping a family through a difficult period, reducing use of emergency services.

In general, the role of the practice team in working with vulnerable families is to respond to minor problems and crises so that they do not progress to major problems and crises. Accessibility and continuing support may be sufficient at this stage. Referral to other agencies may be necessary, but when these agencies cannot cope and have long waiting times, the primary care team may be the only support available.

By responding to day by day problems and concerns, an important function of primary care is to build a “savings bank” of trust, whose value lies in the prevention and management of future problems. The redeployment of health visitors could seriously deplete this reservoir.

The nature of preventive work is that success comprises events which do not happen – which makes it difficult to demonstrate that prevention has been effective. It is a mistake to underestimate the effect of case-finding in general practice in improving the match between need and provision.

It was noted that while services for children had been subject to many changes and re-organisations in recent years, general practice has remained a constant feature.

The only other universal service for children of school age is the school health service, but this is under-resourced and schools vary in their willingness and ability to support vulnerable families. It was noted that many schools try to provide a “safe haven” for children from vulnerable families.

Relationships with social work are often a problem. On the one hand, the group acknowledged the statutory role of social work departments in child protection, their lack of resource to address this task and the criteria and procedures which had been adopted to manage this work. On the other hand, it was felt that the primary care team often holds important information about families, and that better communication of this information would be in everyone’s better interest.

Statutory requirements as to the timing of case conferences often, through short notice, preclude the possibility of GP attendance. The group saw no solution to this problem, other than the need for effective communication between health and social work colleagues prior to case conferences, so that key information is shared.

The group recognized that health and social work colleagues often work to different thresholds in considering the types of problem they can deal with. GPs often felt that their assessment of a situation, resulting in a social work referral, was under-valued by social work colleagues, sometimes without reply.

There can also be structural problems, when a practice population straddles two or more social work department areas, or CHCPs, making it more difficult to establish inter-professional communication and understanding, based on joint experience of shared cases.

In general, the group felt that inter-professional relationships should be nurtured on the same basis as relationships with patients – based on contact, continuity, communication and trust. The difficulty in establishing such relationships is less at the professional level, and more in terms of the structures in which professionals work, their policies and lines of accountability. It was felt that both health and social work management need to be charged with responsibility for making better inter-professional working possible, at the level of local teams of colleagues working together.

It was felt that general practice could and should contribute more effectively to local and national policy for working with vulnerable families. A negative consequence of the reduced GP voice within CHCPs was that policies had been developed without recognition of the important contributions which primary care teams can make.

SOLUTIONS

Many of the tensions arising from current and proposed policies stem from the increasing scale of the problem of vulnerable families and the lack of resources to deal with it. Better management and policy can make more efficient use of resources, but cannot make up for a fundamental lack of resources.

Concentration on the use of resources “downstream”, aiming to help the most severely affected families, makes only short term sense, especially if it weakens upstream activity, concerned with delaying preventing or ameliorating problems in the future.

It was felt that the system does not sufficiently recognize or value the informal knowledge, contacts, relationships and trust that exist within primary care. Rather than weakening this aspect of services, it should be strengthened, for example by re-introducing and re-evaluating child surveillance, especially in areas affected by recent increases in the prevalence of child poverty.

The central, universal, unconditional and informal nature of primary care, allied to high rates of contact, provides huge advantages in establishing and maintaining relationships with vulnerable families.

Practices need to ensure that important information is shared, on a regular, informal basis, between members of the primary care team

Teams also need to be kept up to date concerning the range of available local services to help vulnerable families.

The success of professional relationships, between colleagues working within different teams and organisations, depends on the same ingredients as successful relationships between patients or clients and professionals, namely contact, continuity, understanding and trust between people who know each other well. The system needs to recognise, value and support the nature of such relationships.

Putting general practices at the centre of “upstream”, anticipatory and preventive activities concerning vulnerable families – in effect, providing a hub for other services – is complicated by the number of small practices working in severely deprived areas, and their fragmentary effect on the work of other services. Practices need to identify their lead professional, co-ordinating activities within their practice, and to consider the ways in which they could work more effectively with other practices and with other agencies. Joint working on an area basis would serve to share experience and reduce variability between practices.

For children over 5, the primary care team needs better relationships with the school nurse service. Conversely, there is a need not only for more school nurses, but also for nurses to have better links with local practices.

The knowledge of primary care staff about the most vulnerable families could be contributed more effectively to statutory case conferences, for example by better communication beforehand, and greater flexibility in the location of such conferences.

It is important for the system to take account of the views and experience of families using services.

There is a need for more effective and quicker dialogue between practices providing front-line services and those responsible for local and national policy on child welfare and vulnerable families.

BACKGROUND PAPER (PRE-CIRCULATED)

Scotland has a child population of approx 1 million (child defined as under 18 years).

There are 32 local authorities in Scotland who submit an annual survey form providing aggregate data for children going through the process of child protection to the Scottish Government. From the most recent child protection statistics 2007-2008

- there were 12,382 child protection referrals(an increase of 4% compared with the previous year)
- 46% of these referrals were for boys, 50% were for girls, and 4% were for children whose gender was not known (largely due to being unborn).
- 35% of child protection referrals resulted in an inter-agency case conference in 2007/08. This compares to 39% in 2006/07 and 38% in 2005/06.
- For 86% of children who were subject to a case conference, the primary known/suspected abuser was the child's natural parents (where this was known), the same as in the previous year.
- Of the 4,298 case conferences, 65% resulted in the child being placed on the local child protection register. This compares to 68% in 2006/07 and 70% in 2005/06 –this approximates to 2794 children or 1 in 5 children referred into the child protection system are subject to statutory measures.
- 16% of registrations on to child protection registers in 2007/08 were of children who were known to have been previously on a child protection register.
- 48% of all children on local child protection registers were registered because of physical neglect ,23% because of emotional abuse , 21% because of physical injury, 7% because of sexual abuse
- The number of children living with parental drug misusers in Scotland is estimated to be upwards of 59000 (Hidden Harm).

WHAT DOES THIS MEAN FOR GENERAL PRACTICE?

'Vulnerability', 'child protection', 'child well-being', 'child welfare' and 'safe-guarding' all have fuzzy definitional boundaries. Difficulties in understanding the implications and origins of these concepts not only impede general practice from recognising its own role in alleviating difficulties that families encounter but also where we are situated within an integrated world of 'inter-agency' and 'multi-disciplinary working'.

Child Protection has its legislative roots in the criminal justice system focusing on an evidentially–led process to invoke statutory proceedings against families, but from current statistics the number of vulnerable children is unknown, and most probably under-estimated. The identification of and systems for dealing with vulnerability within the locus of child protection decision making contributes to large numbers of vulnerable children failing to reach significant thresholds of intervention and service provision.

Low socio-economic status is an important factor contributing to vulnerability in families and adverse health outcomes for adults and children. Early good health is connected to parental social class and parental health status. Both seem to sustain the inter-generational transfer of inequalities via 'health selection'. This link is very strong - poor socioeconomic status in adults is reflected in the poorer health of their children. For example poverty is the most consistent correlate identified with child neglect and combined with poor parental education and employment contributes to the chronicity of neglect. In a recession, as the level of economic poverty increases, levels of physical and educational neglect also increase.

Child well-being measured across several domains including health and education has resulted in the UK scoring particularly poorly, despite its national wealth, in comparison with other countries. There are very significant economic costs to society through the maintenance of unjust social structures that perpetuate childhood vulnerability.

The identification of vulnerability is a social process of decision making - for example, determining parental behaviours that constitute vulnerability and impact negatively on children. In practice parental addiction problems and mental health issues are concrete medical problems which GPs may be more comfortable in identifying. This process is under-researched but a number of studies have identified common barriers to GP involvement in this process, including fears of litigation (from carers) due to unnecessary referrals, lack of skill and challenges of identification and negative outcomes after referring to social work.

Parents who cause their children to be 'in need' and consequently vulnerable, find difficulty in making decisions, have low self esteem , self defeating behaviour, impaired social skills and communication problems. They are more likely to be socially isolated, with fewer social networks available to them in times of increased stress, and often disengage from the support that is offered.

General practice is one of a number of professions involved in improving outcomes for vulnerable children within a burgeoning number of childrens' departments and services – leading to "atomisation" of the child. A number of significant child protection inquiries have commented on compartmentalism and poor inter-agency coordination, increasingly seen as causes of inefficiency and inadequate outcomes (Baby P, Climbie in recent times, but there is a long history of similar failings cited since the first child protection inquiry in 1945, which was followed by the 1948 Children's Act).As a result of the increased specialisation of children's services, there are intrinsic difficulties in bringing different systems (and those who work within them) into closer working relationships. For general practice this is particularly relevant as the profession needs to emphasise the importance of maintaining a generalist approach to dealing with families and the therapeutic benefits to these families of highly skilled professionals who can treat both the psychological and physical status of children and adults who suffer adverse health outcomes related to vulnerability. We are generally trusted and develop a temporal relationship with our patients which can facilitate their journey into accessing supportive services. GPs are an important link between the real-life circumstances

of vulnerable families to the system of child welfare (a broader conceptual framework than child protection).

Resilience is an important concept in vulnerability in children and families - GPs can contribute precisely because of the generalist skills by improving some of the factors that impact adversely on families. It is an area that is of interest in research terms but should be driven by knowledge of ‘real-life’ accounts of positive impact of the profession on families who are vulnerable.

ANNEX CONTACTS FOR FURTHER INFORMATION

- **Paul Alexander**
  RCGP Scotland
  25 Queen Street
  Edinburgh EH2 1JX
  tel 0131 260 6805
  e-mail palexander@rcgp-scotland.org.uk

- **Dr John Budd**
  Lothian Deprivation Interest Group
  c/o Edinburgh Access Practice
  20 Cowgate
  Edinburgh EH1 1JX
  tel 0131 240 2810
  e-mail John.Budd@lothian.scot.nhs.uk

- **Dr Petra Sambale**
  Keppoch Medical Practice
  85 Denmark Street
  Glasgow G22 5EG
  tel 0141 3346165
  e-mail psambale@btinternet.com

- **Professor Graham Watt**
  General Practice & Primary Care
  University of Glasgow
  1 Horselethill Road
  Glasgow G12 9LX
  tel 0141 330 8345
  e-mail gcmw1j@clinmed.gla.ac.uk