

Deep End Report 12

**Working together for
vulnerable children and
families**

The twelfth meeting of “General Practitioners at the Deep End”, organised jointly with NHS Greater Glasgow & Clyde Health Board

09 September 2010

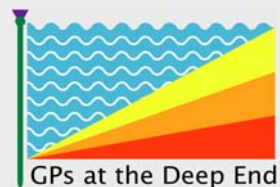
81 practitioners and managers from Greater Glasgow and Edinburgh, including 19 Deep End GPs, met on Thursday 09 September 2010 at the Beardmore Conference Centre, Clydebank, for a discussion about policies and practices for children and families.

SUMMARY

- Practitioners and managers agree that there are not enough resources to respond to need, resulting in a focus on fire fighting, raised thresholds for engagement and missed opportunities for early intervention.
- Local teams are often aware of vulnerable children and families before serious problems develop, but lack the resources to intervene and to make a difference. Investments are needed in home support, free nursery places and other ways of supporting families.
- The many suggestions made in this report can result in greater efficiency, especially via better joint working, but do not address the fundamental problem of resources.
- Hundreds of professional teams are involved in providing care for vulnerable children and families, and all need to work well, both individually and as components of an integrated system.
- The system needs accurate information on the numbers and distribution of vulnerable children and families, including but not restricted to children on child protection registers, as a basis for resource distribution, audit and review.
- Effective joint working depends on colleagues being well informed concerning each others' roles, how they may be contacted locally and the constraints under which they work.
- Information about the progress of particular cases needs to be shared between professions and services, so that each is aware of what is happening. There is an urgent need for bespoke IT which links systems and professionals.
- Pregnancy is an important opportunity to demonstrate the integration of professionals and services working to identify and help vulnerable mothers and their families.
- Professionals and services should be accountable not only for their own contribution but also how this connects with the contributions of others. The "connectedness" of care should be a major policy, management and practitioner objective, concerned not only with joint working around crises, but also continuity of care as required throughout childhood.
- Professionals acquire local knowledge and develop trusted relationships with families that are crucial for long term preventive care. There is a need to support and retain such staff, to value the relationships they have developed and to use the information they acquire, via regular multidisciplinary meetings.

- The hallmarks of a caring system are not only the quality of encounters between practitioners and families, but also the extent to which the system measures itself in providing needs-based support to all who need it, matches rhetoric about joint working by measures to support and review joint working, provides continuity of care and assesses itself against a range of outcomes, including the views of parents and children.
- A caring system should also care for its staff, ensuring reasonable caseloads, sharing the burden and finding practical ways of encouraging and rewarding commitment and continuity.
- An important determinant of service integration is the commitment of senior managers in encouraging, supporting and rewarding joint working by staff within their service.
- The GP contract and/or enhanced service agreements should explicitly support practices in working with vulnerable families in ways that are commensurate with the numbers of vulnerable families within practices.
- Clarity is needed about specific interventions for specific needs at specific points, and whose responsibilities these are.
- The system needs to learn and share examples of how existing resources can best be used, based on experience, audit and evidence.
- The meeting provided an example of how practitioners and managers from different services can learn from each other, share experience, correct misperceptions and discuss how services can be improved.
- The extraordinary nature of the meeting needs to be made ordinary, as part of a learning organization, dedicated to supporting professionals and services working with vulnerable children and families.

“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 Academic Unit of General Practice & Primary Care at the University of Glasgow.



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Full report at <http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend>



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About this report

The purpose of the meeting was to promote discussion between colleagues from different professions, services and organizations. This report comprises a summary of the discussion sessions, followed by a brief summary of the main points and principles emerging from the meeting. The report does not attempt to cover everything that was said, especially detailed comments about particular services.

PARTICIPANTS

Maureen Smith	Chair of the meeting, and chair of the Glasgow LMC
Andrew Lyon	Facilitator, International Futures Forum
Graham Watt	Rapporteur, Professor of General Practice, University of Glasgow

ATTENDING FROM DEEP END PRACTICES (the 100 most deprived practice populations in Scotland)

Name	Location	CHCP	Deprivation ranking	List size
Anna Pettigrew	Springburn HC	GLA (N)	44	1386
Anne Mullin	Govan HC	GLA (SW)	79	8338
Catriona Morton	Craigmillar	EDINBURGH	20	8197
Clare McCorkindale	Kelso St	GLA (W)	57	3238
Linda Cherry	Allander St	GLA (N)	12	4186
William McPhee	Parkhead HC	GLA (E)	16	5116
Jim Farrell	Port Glasgow HC	INVER-CLYDE	84	4195
Jim O'Neill	Lightburn MC	GLA (E)	27	3135
Susan Langridge	Possilpark HC	GLA (N)	18	2206
Euan Paterson	Govan HC	GLA (SW)	32	4005
Elizabeth Day	Bridgeton HC	GLA (N)	36	2646
Emma Shepherd	Easterhouse HC	GLA (N)	4	2430
Judith Marshall	Drumchapel HC	GLA (W)	43	5313
Georgina Brown	Springburn HC	GLA (N)	55	7270
Helga Rhein	Sighthill HC	EDINBURGH	125	1635
Petra Sambale	Keppoch MC	GLA (N)	1	3162
Sara Watkin	Muirhouse HC	EDINBURGH	75	10998
Kerry Milligan	Glasgow Homeless Practice			
Ruth Spencer	Glasgow Homeless Practice			

**ATTENDING FROM SERVICES FOR VULNERABLE CHILDREN AND FAMILIES
IN NHS GREATER GLASGOW & CLYDE**

Name	Title	Organisation
Adela Heaney	Team Leader	South West Glasgow CHCP
Andrew Kirkland	Trainee Social Worker	Children & Families
Anna Donnelly	Team Lead	East Glasgow CHCP
Anna Stallard	Consultant Clinical Psychologist	North Glasgow CHCP
Anne Marie Forde	Specialist Health Visitor	North Glasgow CHCP
Anne McGinley	Team Lead	East Glasgow CHCP
Anne McGowan	Team Leader	South West Glasgow CHCP
Barry Syme	Area Principal Psychologist	South East CHCP
Cath Krawczyk	Public Health Principal Children/YP	NHSGG&C
Cathy Coll	Assistant Service Manager, Children's Services	South East CHCP
Cathy Harkins	Lead Midwife	Midwifery
Catriona Harper	Senior Health Improvement Practitioner	South West Glasgow CHCP
Catriona Renfrew	Director of Corporate Planning	NHSGG&C
Clare Hastie	Team Leader	West Glasgow CHCP
Diana Weir	Team Leader	West Glasgow CHCP
Donna Hunter	Community Paediatric Nursing Manager	CCH rep
Donna MacLean	Team Leader	West Glasgow CHCP
Elaine Millar	Social Worker	West Glasgow CHCP
Flora Dick	SCM for Special Needs in Pregnancy	Midwifery
Gillian Thomson	Health Visitor Team Leader	South East CHCP

Irene Hoskins	Team Leader	West Glasgow CHCP
Irene Woods	Lead Midwife – PRM	Midwifery
Jacqui Howison	Consultant Clinical Psychologist/Lead	Children & Young People's Specialist Services
Janine McAlister	Team Lead	East Glasgow CHCP
Jean Herbison	Clinical Director in Child Protection	Women & Children's Services
Joanne Garrett	Service Manager, Children's Services	South East CHCP
John O'Dowd	Consultant	Public Health Medicine
Karen McFadden	Nurse Team Leader	South West Glasgow CHCP
Karin O'Hagan	Team Lead	East Glasgow CHCP
Lesley Binnebesel	Midwife	Women & Children's Directorate Services
Lesley McKenzie	Social Worker	West Glasgow CHCP
Linda de Caestecker	Director of Public Health	NHSGG&C
Lorna Kelly	Head of Policy	NHSGG&C
Lucy Morton	Service Manager	West Glasgow CHCP
Lynn Mckenzie	Health Visitor	South East CHCP
Margaret O'Donnell	Midwife – Homeless	Midwifery
Margaret Ritchie	Team Leader	Child & Adolescent Mental Health Services
Marianne Elliott	Team Lead	East Glasgow CHCP
Marie Callan	Team Leader	West Glasgow CHCP
Marina Madden	Service Manager	East Glasgow CHCP
Mark Feinmann	Director	East Glasgow CHCP
Mary Ann Tanzilli	Parenting Co-ordinator	South East CHCP
Pauline Johnstone	Staff Nurse	West Glasgow CHCP
Roslyn Crocket	Board Nurse Director	NHSGG&C
Ruth McDonald	Assistant Service Manager	Glasgow Bridges - Aberlour

Stephen McLeod	General Manager	Children & Young People's Specialist Services
Una Proven	Team Leader	South West Glasgow CHCP

AIMS OF THE MEETING

This day event for practitioners, managers and policy makers aimed to:

- explore how a range of practitioners work to support vulnerable children and families.
- assess together the issues and gaps in current practice, systems and services and how these might be addressed.
- develop a shared view of how children's services should develop in NHSGGC.

PROGRAMME

WELCOME AND INTRODUCTION

Maureen Smith, GP and Chair of the Greater Glasgow & Clyde Local Medical Committee opened and closed the meeting. The rest of the meeting was facilitated by Andrew Lyon from the International Futures Forum

PRESENTATIONS

The meeting began with seven short presentations (see ANNEX C), providing different professional and service perspectives.

- **Petra Sambale** GP, Keppoch Medical Centre, Possilpark
- **Anne McGinley** Team leader, Children and Families, East Glasgow CHCP
- **Elaine Millar** Social Worker, West Glasgow CHCP
- **Margaret O'Donnell** Midwife, Glasgow Homelessness Partnership
- **Catriona Morton** GP, Craigmillar Medical Group, Edinburgh
- **Margaret Ritchie** Team Leader, Child & Adolescent Mental Health Services
- **Donna Hunter** Community Paediatric Nursing Manager, Children and Young People's Specialist Services.

PLENARY DISCUSSION

MORNING DISCUSSION GROUPS

- What works well?
- What works not so well?
- Additional issues

LUNCH

PLENARY SESSION

Review of the morning and questions for afternoon discussion

AFTERNOON DISCUSSION GROUPS

- What can I do differently?
- What do others need to do differently?

FINAL PLENARY

REPORT OF MORNING DISCUSSIONS

What works well?

- Experienced staff with long term knowledge and experience of families in an area are a hugely valuable resource in providing appropriate, personalized, continuous and trusted care.
- Health visitors have a key role and are generally utilized well but are in short supply.
- Although health visitors work across the 0-19 yr age range with school nurses, this was not known about in all areas and HVs were perceived to lose contact with families after a child's 5th birthday.
- Team working often works well, and the introduction of new types of staff (e.g. health care support workers) has expanded the volume and nature of what teams can do. There is concern, however, that changing skill-mix should not de-skill what teams provide. HCSWs can add to teams but are not a substitute for more highly skilled staff, and need supervision.
- Multidisciplinary meetings and registers of vulnerable families are the key to sharing information
- Collaboration across professional and service boundaries works best when colleagues know each other's names and have developed a working relationship based on mutual understanding, respect and trust.
- Team funding based on postcodes has helped distribute some resources towards areas of unmet need
- Assessment processes can work well, especially when carried out jointly and early
- There have been excellent developments in voluntary organizations, which statutory services need to know about
- Outreach services can make the difference in meeting some families' needs, but there is the question of how long to persist with outreach activities, when families do not respond.
- Administrative support can release professional time by making it easier to record and process information (e.g. creating templates for staff using a dictaphone or computer voice activation programme).
- A one stop clinic was described, which provides several services at one visit, including access to financial advice, a dental nurse and a community psychiatric nurse.
- In the East CHCP in Glasgow, the Mental Health Service has recently changed to a self-referral system with triage which has cut waiting times substantially.
- In her description of services at the Keppoch Medical Centre in Possilpark, Petra Sambale described how attachment between parents and children can be assessed at all contacts with the family.

What does not work well?

- While everyone is committed to helping vulnerable families, definitions of vulnerability vary, resulting in different thresholds for engagement and action.
- Focusing on the most vulnerable families feels like fire fighting, doing too little too late.
- Staff struggle with too much to do and not enough staff to do it.

- Funding for initiatives is often short term. The system needs to take a longer view.
- A good assessment is of little value when there are not the resources to address the problems identified.
- Fragmentation occurs when there is uncertainty about handover arrangements and about who holds and coordinates the family health record.
- Communication between professions and services is often dysfunctional. This needs to be looked at in detail wherever it occurs so that it is clear where and what the communication difficulties are.
- For GPs, the financial incentives of the Quality and Outcomes Framework do not prioritise working with vulnerable families. Rather, the emphasis has been on chronic disease management. Many GPs feel this has resulted in a distortion of the role of general practice.
- Individual practices have shown what can be done, but generalisation of this work is likely to require explicit support, via the QOF or Enhanced Service arrangements.
- Other professions would welcome clarification and consistency concerning what general practice has to offer.
- Within general practices, there are many salaried doctors with commitment and ideas but, not being partners, they are unable to change practice systems.
- Families should be given more choice in what they want and who they want to deliver it.
- The disconnection of midwives from general practices is a problem, especially concerning the sharing of information and the coordinated management of pregnant women with medical and other problems. GPs cannot access the maternity record.
- A social worker felt that there was an unspoken view of social work as “the enemy”.
- It was recognized that social work is largely consumed by crisis intervention and that the pressure of this work can leave little time or resource for less vulnerable families.
- Health visitors have become more focused in their work. It was questioned whether health visitors still have time for a universal role, knowing all families in a practice.
- Services stretched over large areas are more likely to be impersonal, lacking local knowledge and continuity. It is difficult for such services to develop effective working relationships with lots of different general practices.
- It was acknowledged that the most vulnerable families need help from the most experienced staff.
- The waiting time of the Child and Adolescent Mental Health Service was felt to be too long for the service to be useful.
- Social work eventually refers children on to adult services. If they don't engage after three letters, the contact is discontinued.
- Outcomes for children removed from their homes are not good. Alternatives to removal need to be evaluated.

Additional issues

- Many commented on the range of services involved with vulnerable children and families, and the need for professional understanding and respect concerning each other's roles.
- There was some disappointment expressed at the lack of understanding and respect for new roles.

- Visions of what needs to be done overlap but may not coincide. Meetings like this highlight similarities and differences between groups and help to move towards a shared vision.
- Shared assessment tools and language are necessary if professions and services are to work more effectively together.
- Continuity and communication are the keys to better long term outcomes.
- Referral between services is a mutual activity with responsibilities at both ends, in terms of communication and feedback.
- Recent developments in midwifery and health visiting, plus the withdrawal of child surveillance, have undermined the knowledge of primary care teams concerning young families.
- Team work requires the right balance of skills. There is concern whether colleagues with the necessary skills will be available in the future.
- It is not clear to what extent meetings in general practice could be used as a basis for communication and collaboration with colleagues working outside the practice.
- The comment was made that the two GP presentations were from practices which appeared to have access to additional resources. Their examples would be hard to follow in places without such resources. Catriona Morton from Craigmillar replied that the practice did not have additional resources, but were fortunate in having a longstanding, attached midwife, with whom it had been possible to develop not only their services but also their relationships with patients.
- It is important to develop relationships with families and to balance the needs of parents and children within families. The focus needs to be on the family as well as the child, supporting carers who provide most of the care for children.
- Professional knowledge, skills and competence are essential but need to be combined with a compassionate approach.
- A compassionate approach reflects not only the personal qualities of the carer, but also professional skills which can be taught.
- Personal continuity is crucial for vulnerable families, who need to be able to trust the professionals working with them.
- Confidentiality is very important, especially when sensitive information is shared across services. Patients need to be informed about this, or else trust can rapidly be lost.
- Investing in relationships takes time. Too much report writing reduces the time professionals can spend with families.
- All staff in contact with children may need training in how to enquire and respond when concerned about sensitive issues such as domestic abuse.
- Good practice, based on experience, audit or research, needs to be shared, so that the organization and content of services is more consistent.
- Leadership is important throughout the system and takes various forms according to what needs to be achieved.
- Large caseloads with insufficient time and resource put staff under pressure, make them feel vulnerable to criticism and encourage defensive practice.
- The school nurse can be central in the coordination of care for children with complex needs, but “most GPs don’t know about school nurses”. A list of school nurses is being collated and could be made more widely known.
- Health and social work services can only do so much. There is a need to build community support.
- Practices and teams need to know what other services are available in their area.

- Many GPs at the meeting did not know that children could be referred directly to a child psychologist.
- Triple P is a welcome development, but involves a large number of new working relationships that have to be established and maintained.
- Child neglect is a difficult issue, which may not come to the attention of services, especially when there is no identifiable harm. GPs are sometimes the only people to pick up early warning signs.
- Many participants commented on the big picture, concerning the causes of vulnerability in children and families. Even the best organized services cannot affect the root causes of vulnerability or the large numbers of cases currently occurring.

QUESTIONS HIGHLIGHTED FOR AFTERNOON DISCUSSION

Trust and caring

- What are measurable features of a “caring system”?

Professional skills and careers

- How can key staff be supported and retained in deprived areas?
- How should skill mix develop?

Professional communication and joint working

- How to build professional understanding and respect?
- How is knowledge about patients best shared between professionals (blue prints for multidisciplinary, multi-agency meetings, record sharing etc)?
- How can experience and views be shared between front line practitioners?
- How can service interfaces be improved (GP–SW, GP–MW etc)?
- How to integrate antenatal and postnatal care – who does what?

Breaking the cycle: early intervention

- What problems are we trying to solve?
- Is there the right balance between upstream and downstream activities?

Parenting initiatives

- Knowledge and consistency
- Integration of parent and child approaches

Capacity to act: ability and resources

- Where are the resources we need?

REPORT OF AFTERNOON DISCUSSIONS

Eight groups chose to address a wide range of issues:

- Communication
- Early intervention – breaking the cycle
- What is a “caring system”?
- Suggested improvements
- Involving children and parents
- Joint learning
- Developing skill-mix
- Staff recruitment and retention in deprived areas
- Advocacy

The issues addressed by most groups were communication and breaking the cycle.

Communication

- Integrated care, based on effective joint working, depends on professions understanding and respecting their different roles and circumstances, and building up shared experience and trust.
- The building blocks of an integrated system, therefore, are a huge number of inter-professional and inter-service relationships, each of which requires attention.
- Individual practitioners need to think not only about their own role, but also how it connects with the roles of others and what needs to be communicated, to whom and when, to ensure integrated care.
- Co-location is desirable but not essential. A more important feature is regular and reliable communication between colleagues who know each other and work at the relationship. Face to face meetings are needed initially to establish contact, after which phone or email may be sufficient.
- Local forums could facilitate inter-professional exchange, but would need to be supported at a high level within each practitioner group, to allow the planning of such forums and to enable staff to take part.
- An electronic multidisciplinary record, owned, maintained and used jointly, could help overcome the practical difficulties of arranging face to face meetings.
- Each part of the service should produce a description of its role, for inclusion in an induction leaflet for practitioners arriving to work with vulnerable children and families. Generic aspects of this will be common to many areas, but need to be complemented with local details.
- The contributions of different professions and services should be described as parts of a whole system, showing the paths that a family might follow.
- The challenge is not only to communicate information; it is to communicate information in ways that result in the information being used.

Early intervention: breaking the cycle

- Services aimed at all families should be audited regularly to review coverage.
- Staff with universal contact with families may need training in open questioning and enquiry skills, building on screening approaches used to detect domestic abuse and alcohol problems.
- Knowledge about families is based mainly on contact with families and is acquired, formally and informally, and cumulatively, by a wide range of staff. At a local level, there is a need for mechanisms through which such information can be shared, and preventive action taken if indicated.
- Support has to be provided in ways that are acceptable and meaningful to families. In relation to the Triple P parenting programme, it was said “Not everyone wants to go to the library. Can we make better use of natural gathering places. Is the pace and are the literacy demands too challenging for some of the most vulnerable families?”
- Formal screening is time consuming and tends to produce large numbers of false positives. Professional judgment may be a more efficient way of identifying vulnerable families at an early stage, but requires experienced professionals who know their population well and have mechanisms for sharing and acting on such information.
- There is a need to free up professional time, so that support can be given to families who need it. “Report writing times are measured, but not the outcomes for children and families.”
- Information-sharing depends not only on technology, such as shared assessment methods and information systems, but also inter-professional relationships, exchange and trust.
- There was a general feeling that while problems were often identified at an early stage, when interventions could make a difference, the pressure under which most services work means that thresholds for intervention tend to be high, so that opportunities for early intervention are missed.

What is a “caring system”?

- The hallmarks of a caring system are not only the quality of encounters between practitioners and families, but also the extent to which the system measures itself in providing needs-based support to all who need it, matches rhetoric about joint working by measures to support and review joint working, and assesses itself against a range of outcomes, including the views of parents and children.
- A caring system should also care for its staff, ensuring reasonable caseloads, sharing the burden and finding practical ways of encouraging and rewarding commitment and continuity.
- A caring system needs to take the long view, assessing how short term inputs contribute to long term outcomes. There are no quick fixes.
- The starting point of a caring system for vulnerable children and families is knowing how many such families there are, where they are located and their points of contact with the system.
- The most important determinant of service integration is the commitment of senior managers in encouraging, supporting and rewarding joint working by staff within their service.
- The quality of the system depends on the quality of each local component. Every local team has to work well. There are hundreds of teams within the system.

Suggested improvements

The following improvements were proposed:

- The extent of integrated care, within families, within teams, across services and over time are all measurable aspects of care, which need to be measured, if fragmentation is to be avoided.
- A useful way of assessing integration involves a simple hierarchy of engagement between services:
 - 0 = Unaware
 - 1 = Aware
 - 2 = Communication
 - 3 = Cooperation
 - 4 = Collaboration
- The system needs to find a way of valuing and retaining experienced staff with substantial local knowledge. Such attributes may take years to replace, if staff leave or are relocated.
- There is a need for supported accommodation for high risk families, enabling them to stay together during a crisis. This is currently only available when addiction is one of the problems.
- Health and social care could make better use of voluntary sector and community support, which means it must be someone's job to identify, foster and support the use of such resources at a local level.
- Could pregnant women have a choice as to who is the lead professional in their care – midwife, health visitor or GP?
- Pregnant women with multiple problems should benefit from early intervention, such as a visit by their health visitor and automatic inclusion in a parenting programme, not waiting for problems to happen and avoiding the stigma of referral to parenting classes after something has happened.
- The GP contract and/or extended service agreements should explicitly support practices in working with vulnerable families in ways that are commensurate with the numbers of vulnerable families within practices.
- GPs could be more helpful to social work especially by attending child protection meetings, but the timing, venue and notice of such meetings often makes it difficult for GPs to attend. Can this longstanding problem be solved?
- Social workers could be more helpful to general practice, by having dedicated attachments to practices, taking part in review meetings and being accessible.
- Opportunistic visits by qualified staff can be a useful tool when there are concerns about a family or child, but this is only possible when the visiting professional is known and trusted by the family.
- Schools could play a more significant role but need to be supported as part of the system. The inverse care law works in schools as well as the health service, with fewer experienced teachers in very deprived areas, and greater reliance on short term staff.
- The extension of the health visitor role from 0–4 to 0–19 was welcomed, but there was doubt about whether there will be the resources to allow this to happen in practice.
- Local teams need to review whether they have or have access to the necessary range of skills and resources.
- Social marketing can be helpful in determining whether the system, and the services within it, are fit for purpose, in terms of acceptability, accessibility and use by vulnerable families.

- Innovative incentives are needed to engage with very hard to reach families. “More of the same won’t do.”

Involving children and parents

- The meeting largely reflected professional experience, views and concerns. More needs to be done in developing and sharing ways of involving children and parents.
- “Children have no voice, are not asked and are not listened to.”
- What is the system doing to find ways in which children can be included appropriately as subjects and not the objects of actions by others?
- What can be learned from Childline?
- Health visitor time needs to be freed up for parenting work. How can the work of the team be shared to allow this? Examples vary and there is scope for identifying and sharing effective practice.
- What is the right mix of parenting initiatives, and deployment of staff and resources between antenatal care, nursery schools, general practices and other points of contact?

Joint learning

- Different parts of the system should learn from each other. For example, it was said that statutory services could learn from the voluntary sector.
- There is substantial variation within practices and services as to how care is delivered.
- There are few ways in which practitioner, practice and service experience can be shared across the system, based on existing activities or on new developments.
- The meeting demonstrated on several occasions how comments on one part of the system by colleagues from another part, could be poorly informed. It also showed how quickly inter-professional learning can take place, when problems and experiences are exchanged.
- The many services for vulnerable children and families need to be developed and integrated as a learning organization which values and supports the sharing of experience, views, audit, evidence and opportunities for professional development.

Developing skill mix

Many ways were described for extending the team approach:

- Health care assistants in drug clinics.
- Door chapping, and other informal contacts, to boost attendance.
- First contact at reception (meet and greet).
- Nursery nurses can be very skilled and a great resource.
- Stress counsellors.
- Breast feeding support as part of Triple P.
- Family mental health workers.

Such developments can enhance but should not replace the efforts of skilled staff. New staff should be 100% part of the team, and supervised as necessary.

Staff recruitment and retention in deprived areas

- “Golden hellos” may help to recruit staff to deprived areas.
- The induction of new staff should introduce newcomers to the range of local professionals and services.
- Good practice should be shared, via regular, supported peer support and review meetings.
- Managers must understand the service pressures, supporting staff at times of stress and crisis.
- Caseloads have to be reasonable, and the burden shared.
- Administrative support may release professional time.

Advocacy

- Improving the volume, quality and integrated nature of services will do nothing to change the upstream factors in society which determine the number of vulnerable families.
- Practitioners with front-line experience are a valuable source of information for advocacy. There is a need to give voice to this experience, individually and collectively.

SUMMARY

Increasingly, health professionals must ask themselves not only “What do I do?” but also “What am I part of?”

Don Berwick

Institute for Health Care Improvement, Harvard University

These summary points are drawn from the reports of group and plenary discussions and presentations made at the meeting. Having explored how different practitioners work to support vulnerable children and families, and assessed together the issues and gaps in current practice systems and services, it is hoped that this record of the meeting will help to develop a shared view of how children’s services should develop in NHS Greater Glasgow & Clyde.

A whole system approach

- Hundreds of professional teams are involved in providing care for vulnerable children and families, and all need to work well both individually and as components of an integrated system.

- An effective system that cares for vulnerable children and families depends on three types of shared knowledge:
 - First there should be accurate information on the numbers of vulnerable children and families, based not only on child protection registers, but also children and families at risk based on agreed risk factors. Such information should inform resource distribution and provide a basis for audit and review.

Primary care teams who know their patients and communities well acquire additional knowledge, some of it recordable but other aspects just held in the memory, which is helpful in assessing situations and deciding when action is or is not required. This knowledge is acquired by many members of the care team, and needs to be collected, collated, shared and reviewed on a regular basis.
 - Second, everyone working in the system should be well informed concerning the roles of other professionals, how they may be contacted locally and the constraints under which they work.
 - Third, information about the progress of particular cases should be shared between professions and services, so that each is aware of what is happening, allowing coordinated care, as and when required. There is a need for bespoke IT linking systems and professionals.
- Shared knowledge requires active measures to collate information, to make it available and to audit its use.

Balance

- Effective care requires a balance between “downstream” activities, dealing with problems after they have occurred, and “upstream” activities, trying to anticipate, prevent, delay or lessen the severity of problems.
- Actions to “break the cycle” can only be applied upstream, via societal measures and early interventions
- If resources are concentrated downstream, such services may have no protection from preventable cases which have not been prevented.
- Social work services, and child and adolescent mental health services, are largely consumed by downstream activities, and need more resource, and help from other groups, principally by managing cases more effectively at an earlier stage.
- General practices, providing unconditional support for the problems presented by patients, have regular contact with young families, combining contact, coverage and continuity with long term relationships, and are well placed for “upstream” activity. However, identifying problems and knowing what needs to be done are insufficient. Practices need to organize their information and activities to best effect, including how they work with other professionals and services.
- Investment is needed in home support, free nursery places and other ways of supporting families.
- The presentations at the meeting showed what can be done by committed general practices, building on local opportunities for joint working with midwifery and social work. However, such examples are not typical. For larger numbers of practices to follow such leads, additional resources are needed, for example to maintain and use at risk registers, via enhanced service arrangements or changes to the GP contract.

Coordination and integration

- Pregnancy is an important opportunity to identify vulnerable women and their families, to develop and consolidate their relationship with key practitioners and to ensure appropriate communication and coordination.
- Recent developments in midwifery have tended to exclude general practices from the care of pregnant patients, resulting in communication gaps and reductions in the continuity and coordination of care. As maternal morbidity and mortality during pregnancy is now more likely to be due to co-morbid conditions, other than the pregnancy, there is a particular need that care should be shared, especially in severely deprived areas, where multiple morbidity and social complexity are the norm (See ANNEX B).
- Professionals and services should be accountable not only for their own contribution but also how this connects with the contributions of others. Professionalism involves asking not only “What do I do?” but also “What am I part of?”
- Fragmented care is seen in partial approaches to patients’ problems, discontinuity, poor coordination and incomplete population coverage. Whatever the excellence of individual components of care, integrated care requires that they are connected with each other. The “connectedness” of care should be a major policy, management and practitioner objective, concerned not only with joint working around crises, but also continuity of care as required throughout childhood.

Resources

- Although socio-economic deprivation and its consequences are concentrated in some areas (two thirds of cases on the Glasgow Child Protection Register (CPR) are registered with one third of general practices, all in the Deep End), it is also distributed more widely, making it a challenge to allocate resources fairly.
- Cases on the CPR are a substantial underestimate, however, of the numbers of vulnerable children and families at risk. The system needs to be better informed about the numbers and distribution of such cases and to continue the process of allocating resources where they are most needed.
- A clear message from the meeting is that resources are very stretched in deprived areas, limiting the capacity to act and raising thresholds for action to too high a level.
- Better use needs to be made of existing resources, freeing up staff to do what only they can do, and ensuring good communication and coordination
- Practitioners with substantial local knowledge and experience based on long term relationships with families are a hugely important resource, difficult to replace and should be better supported to work in such a challenging environment.

A learning organization

- Experience and views need to be complemented by audit and evidence so that the system as a whole is consistent, effective, efficient and equitable.
- Clarity is needed concerning specific interventions for specific needs at specific points and whose responsibilities these are.

- There are too few opportunities for exchange of evidence, expertise, experience and views across professional and organizational boundaries. Investment in such exchange is a pre-requisite of integrated care.

Graham Watt

Professor of General Practice

University of Glasgow

ANNEX A SUMMARY OF DEEP END 3

Deep End Meeting 3

The GP role in working with vulnerable families

Ten Glasgow GPs met on Friday 22 January 2010 at the University of Glasgow for a workshop on the contribution of general practice in 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.

ANNEX B ONE YEAR OF PREGNANT WOMEN BOOKING WITH RISK FACTORS IN A DEPRIVED PRACTICE

[**CS** = Caesarean section, **PIH** = pregnancy-induced hypertension]

- Drug-dependent, on methadone 80, alcohol, one child in care
- Drug-dependent, on methadone, 2 DVTs, injecting
- Turkish, husband translates
- Chinese, syphilis on booking bloods
- Depression, IVF
- Depression
- Turkish, anaemic.
- Cystic fibrosis carrier- anxious, for screening
- Para 3, BMI 49, mental health issues, previous CS, previous premature birth, previous PIH
- Para 6 + 3. Ninth pregnancy!
- Mobile - multiple recent moves, partner major mental health problems + drug dependence
- Just arrived from Bangladesh ?entitled to NHS care - no English, previous CS, high blood pressure
- Latvian, partner soldier in Afghanistan
- Depression, previous cannabis use, family problems+, brother murdered, chlamydia
- Obese teenager
- Turkish, first child died neonatally of genetic skin problem ?what. Other child has leukaemia
- Rheumatoid arthritis, on steroids
- History of mental health problems, alcohol use, cocaine, partner drug user, SW involvement, drug dealing discovered during pregnancy, partner sent to prison
- Obese smoker
- Obese - BMI 41
- Partner paranoid, ex-prison, using drugs, has knife as weapon, SW involvement, previous baby cleft palate
- 3 previous CSs
- Previous ectopic, previous crack cocaine addiction
- Needle-phobic, chlamydia
- Obese, depression, gestational diabetes, family problems+
- Asthma
- Asthma, clotting disorder (likely to get clots), obese
- Asthma, depressed
- Partner alcohol++, traveller - poor attender
- Teenager with concealed pregnancy, late booker
- Para 8 - 5 children in care. Obese, hypothyroid
- Depression
- Previous CS
- Obese, previous CS, history of domestic violence (SW involved)
- Asthma, previous CS
- Previous CS, gestational diabetes (on insulin)

- Turkish - no English
- Previous premature labour (aged 14), mother drug-dependent
- Asthma, stress - partner issues
- Homeless accommodation - mobile -multiple changes of address, mental health concerns
- Previous IUGR/small baby
- Obese
- Turkish - needs translator
- Obese, previous PIH, previous chlamydia
- Indian, low BMI
- Twins, African
- History of ecstasy use, not clear if current drug use, previous small baby
- Post natal depression
- Partner drug user+, SW involvement and concerns, homeless
- Depression
- Drug dependent, difficult++ communication, hostile, SW involvement
- 17 year old smoker
- Previous depression, previous small baby
- Chinese
- Asthma
- Epilepsy- DNA epilepsy clinic, still fitting regularly
- Asthma, counselling (counsellor has concerns), previous severely ill in pregnancy (ITU), child has genetic condition
- Previous CS, child has a tumour
- Both parents dead, eating disorder
- Both children previously on CPR, SW involved
- Severe domestic abuse / violence. Concerns++.
- Drug-dependent: on methadone and diazepam. Partner in prison
- Family mental health problems+, brought up by aunt
- Mental health problems, anxiety, depression, 2 previous CS, BMI 47
- Turkish- no English
- Depression, hypothyroid
- Jehovah's witness, needs translator
- Depression
- ADHD, asthma
- Previous anencephaly and another baby died neonatally
- Asthma
- Previous CS
- Huge post partum haemorrhage in previous pregnancy
- Both parents alcoholic, teenager
- Hypothyroid, Indian, no English
- Osteosarcoma + leg prosthesis, back surgery too
- Thyroid cancer - on thyroxin
- Saudi Arabian - needs translator
- Catheterised, severe long-term mental health problems, on anti-psychotics, SW involvement
- One child on supervision order (SW involvement+)
- Obese

- Obese (BMI 47)
- Late booker, 2 children supervision order, SW involved+, brother and partner both in prison - violence+/weapons
- Previous depression
- SW involvement (ex-partner schedule one offender)
- Teenager brought up in foster care
- Depression, on treatment, high blood pressure
- Depression, on treatment, abusive partner
- Teenager, chlamydia
- Postnatal depression, chlamydia, self harm
- 8th pregnancy, one child with her, bipolar, SW
- Para 7, 4 previous antenatal or neonatal losses, psychosocial problems, SW
- Depression, previous drug use / Hep C
- Rare vasculitis, bladder cancer, previous strokes, asthma
- Teenager, cannabis, low BMI, eating disorder
- Domestic violence+, in refuge, other problems
- Depression, chromosomal abnormality
- Previous Em section - child very disabled
- Depression, previous drug use
- Depression, previous alcohol
- Catheterised, severe long-term mental health problems, on anti-psychotics, SW involvement (2nd pregnancy in the 12 months)
- Arabic only speaker
- Concealed first pregnancy - stillbirth, concealed body
- Eating disorder
- Thyroidectomy
- Depression, emotional issues, previous bulimia
- Major medical problem, SW involvement, children in care

Overall figures

- 168 women
- 18 teenagers (11%)
- 64 primiparous (39%)
- 34 born overseas (21%)
- 10 needed translators (6%).

Overseas-born

- Polish 10
- Turkish 8
- Chinese 3
- Middle East 3
- And one from each of the following: Zimbabwe, Nigeria, Kenya, Somalia, Bangladesh, India, Pakistan, Latvia, Lithuania.

Translator needs

- Turkish 4
- Arabic 2
- Polish 2
- And one each of: Indian, Polish, Bangla.

Very major obstetric history*	Numbers	Comments
Grand multiparous	4 with >7 previous pregnancies	All had significant other medical/psychiatric conditions
Gestational diabetes	2	
Very severe past foetal or neonatal losses	4	Only if >2
Twins	2	One miscarried
Concealed pregnancy	1	All had significant other medical/psychiatric conditions

*generally excludes Caesarean sections, medical problems, low birth weights, single episode foetal/neonatal loss, obesity, etc.

Medical problems*	Numbers	Comments
Hypothyroid	5	
Rare severe vasculitic disorder	1	Very high risk: multiple previous strokes, bladder cancer
ADHD	1	Conceived on treatment
Thyroid cancer	1	
Osteosarcoma	1	Femur prosthesis
Myasthenia Gravis	1	
Syphilis	1	Diagnosed at booking
Rheumatoid arthritis	1	On steroids
Epilepsy	1	Frequent fits
Hepatitis C	1	Lost partner to drug use
Suprapubic catheter/severe urine infections	1	Multiple severe other psychiatric problems

Multiple DVTs	1	Current intravenous drug use
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**Not included – asthma, hypertension etc.*

Eating disorder/ psychiatric/drug/ alcohol/SW concerns*	Numbers	Comments
Drug misuse	15	One current injecting. Several on substitute scripts
Alcohol excess	3	
Current Social Work involvement	18	
Known domestic violence	6	One severe current; one in refuge (fled partner).
Eating disorders	5	
Major mental health problems	3	On anti-psychotics/bipolar etc

**Not included - depression, anxiety, stress, phobias.*

ANNEX C PRESENTATIONS

Working Together for Vulnerable Children and Families

Petra Sambale, GP, Keppoch
Medical Centre, Possilpark

Keppoch Medical Practice

- Qof prevalence data
- 100th centile for smoking in cd, epilepsy
- 99th centile for COPD, stroke/TIA
- 98th heart failure, mental health
- Bereavement/Depression/Addiction

Keppoch Medical Practice

- One size does not fit all
- 17 c Practice
- Support vulnerable families and children
- Team Work with Health Visitors

Keppoch Vulnerable Families

- Weekly drop in clinic for parents and children resourced by HV team and 2 GPs (postnatal depression, postnatal care, contraception, smear tests, alcohol, literacy)
- Weekly hourly practice team meeting District Nurses, Health Visitors, Counselor, GP's, Practice Nurses

Keppoch Vulnerable Families Identification and Maintenance

- VF monthly meeting
 - HV, GP, PN, addiction & social worker, school nurse (new), no midwife, but opportunity to speak to Mary Hepburn as SNIP located in Possilpark HC
 - Spreadsheet: most vulnerable, vulnerable, medical needs, addiction, child protection register, in care, pregnant women (team effort), read code, comment box
 - Monthly search newly registered children 0 to 16 years

Keppoch Vulnerable Families Identification and Maintenance

- GPs do case note summaries and identify VF
- Shared care addiction clinic

Keppoch Vulnerable Families

- CONFIDENTIALITY
 - Discussed set up with MDDUS
 - Whenever possible discussion HV / GPs with families
 - Practice newsletter contains information and offers opt out option

Keppoch Experience Evaluation

- Cross fertilisation/holistic family picture
- Education / pathways / informal enquires in a safe environment
- Putting a name to the face when seen e.g. as emergency
- Helpful e.g. when receiving calls from Social Work as on call GP

Keppoch Experience Evaluation

- Supportive meeting / avoidance of over identification with the parents
- Changed record keeping e.g. comments on child / parent interaction, state of presentation
- Writing meaningful reports / new projects e.g. Aberlour bridges referral or vaccination

Keppoch Experience Evaluation

- The CAT worker: "I felt this was a place that can make a real difference in terms of providing a more holistic assessment and the subsequent risk to children. We can explore innovative ways to offer a quicker response to our most vulnerable families"

Keppoch Experience Evaluation

- Social Work Perspective
 - Valuable on many levels like informal discussions around professional processes, available resources and local knowledge, voluntary sector
 - "meetings have benefited some of the families e.g. support, child protection".
- Breaking barriers between professions
 - "The social work department seems to me now more approachable"

Keppoch Experience

- Early Identification & Intervention is possible through Development of Trust / Continuity of Care

IF

- Recruitment, Retention, Resources are addressed

Keppoch Experience

- The info board:
 - Administration Voice / Shifting Attitudes
 - Aberlour project
 - Assertive Catch up Vaccination Project
 - Vulnerable Families sheet example
 - Qof Data of Deep End Practice

THANK YOU



Working Together for Vulnerable Children and Families

Anne McGinley, Team Leader,
Community Nursing, East Glasgow CHCP

MY TEAM

- 3 Teams
- 3 Team Leaders
- Team 1(Townhead,Bridgeton and Whitevale)
- Team 2(Parkhead and Shettleston)
- Team 3(Easterhouse and Ballieston)
- My team=28 staff total
- 9.5 wte HVs
- 2PHN students,
- 8 wte community staff nurses
- 1 wte community Nursery Nurse
- 2 wte Dental Health Support Workers
- 1.2 wte HCSWs

DRIVERS FOR CHANGE

- For Scotland's Children(2001)
- GIRFEC(Scotland Bill 2006)
- Hall 4(Health for All Children 4th ed. 2005)
- Better Health Better Care Action plan(2007)
- Improving Children's Services:Action Plan(2007)
- HMIE-Framework for Inspection
- Public Health priorities & HEAT targets
- Early Years framework
- IAF(Integrated Assessment Framework) and ASL(additional support for learning)
- HPI's(Health Plan Indicators)
- Clinical Supervision and KSF

WHAT WE'RE DOING WELL....

- Strengthening our relationships with SW, GP, Midwives, CYPSS, H Improvement & Education
- Midwifery Interface Steering Group
- Local Management Reviews(LMR)
- Monthly Team Meetings and GP meetings
- Caseload profiling
- "Building Blocks" programme for Staff nurses
- Clinical Supervision
- Opportunities to train & development
- IAF Standard operating procedure(SOP)
- Vulnerable "2s" project
- Audit of records
- Maximising the capacity of the Health Visitor

...NOT SO WELL ?

- Change!
- Evidencing practice
- Lack of linkage with the wider strategy of reducing inequalities and social exclusion with day to day practice
- Failing to share best practice across the city
- Lack of consistency across the city
- Limited networking

TEAM LEAD CONTRIBUTION...

- Support the Team to spend time on activities that will improve outcomes for children
- Promote Midwifery interface
- Reduce duplication and overlap where possible
- Assist the workforce to develop and deploy the appropriate skills for the appropriate task i.e. delegation of work to free up HV capacity
- Enable staff to attend training and updates to ensure they have the knowledge, skills and tools to improve children's lives and what to do if they have concerns about a child eg TRIPLE P
- Implement Clinical Supervision-promote a developing pro-active culture
- Supporting the Senior Nurse and PDN develop systems and processes to ensure robust governance
- A good listening ear and effective negotiation skills!

FUTURE PROGRESS IN HEALTH

VISITING ?....

- Clinical supervision embedded in practice
- Analysis of all job roles to ensure clarity of competencies and skills req'd to do the job
- All staff in Team having the opportunity to undertake Triple P to promote infant, child and family mental health.
- Consistency in application of Policy and approaches to managing Teams in the organisation
- Systematic audit and review of our practice which can show measurable outcomes
- Sharing of ideas, best practice coherence across services to ensure we work in a logical, systematic way to improve outcomes for vulnerable children and families



Working Together for Vulnerable Children and Families

Elaine Millar, Social Work
West Glasgow CHCP

Disclaimer

This presentation inevitably reflects the author's own values, preferences and perspectives. Names, characters, places and incidents should be regarded as fictitious. Any resemblance to actual people living or dead, events or locales is entirely coincidental.

What I Contribute:

1. Myself
2. Time
3. Knowledge

Judgement

- Inevitably involve values and "thresholds"
- Have consequences, good or bad, and therefore involve risk.
- Make a worker accountable for their actions or inactions

What Currently Works Well

Assessment Tools and Frameworks

“A framework on which to base their work and the confidence, insight and sensitivity to adapt that framework as and when this becomes necessary”

-Thompson (2000)

What Still Needs Work

Partnership

“A cross sector alliance in which individuals, groups or organisations agree to work together to fulfil an obligation or undertake a specific task, share the risks as well as the benefits, and review the relationship regularly, revising their agreement as necessary”
(Harrison ET AL 2003)

Collaboration

“Work with another to others on a joint project

Working Together for Vulnerable Children and Families

Margaret O'Donnell, Midwife
Glasgow Homeless Practice



Special Needs In Pregnancy Service (SNIPS)

Consultant Managed Service (Red Pathway)

3 x Band 7 WTE
ASR Link Midwife
Teenage Pregnancy Link Midwife
Homelessness Midwife

4.8 x Band 6 WTE

Currently located in the PRM, Rutherglen Maternity Care Centre & Possilpark Health Centre

Homeless Families Health Care Service

GP

1 x Midwife

5 x Health Visitors

2 x Staff Nurses

1 x Nursery Nurse

1 x Support Worker

Based in the Homeless Health & Resource Centre,
55 Hunter Street, Glasgow

What I Contribute

- 60% allocated time to the homelessness service
- Case Load Holder for complicated homelessness
- Provide care for homeless women in main stream
- Support women back into main stream
- Liaise with various agencies
- Offer advice to women, staff and agencies
- Early visits
- Contribute to short life working groups e.g. Parenting Strategy & SNIPS strategy
- Educational remit to staff in main stream
- Recently co-ordinated a two day educational event on SNIPS
- As a Supervisor of Midwives to expert reviews

What Works Well?

- City wide remit
- Early intervention
- Fast Track to Maternity services
- First point of contact
- Direct referrals
- Links – CPU, Housing Network, Specialist Services, Agencies
- Sign Posting e.g. Intensive Parenting Programme, Advocacy Services & Welfare Advice
- Safety

What Works Not So Well?

- 60% allocated time to the service
- No ID prohibits access to GP services
- Referrals to Social Work Services take too long to action
- Opportunistic visits are often unsuccessful
- Gaps created in follow on care to Health Visitor
- Failed Asylum Seekers / Illegal Immigrant Population
- Destitution



Working Together for Vulnerable Children and Families

Catriona Morton, GP
Craigmillar Health Centre,
Edinburgh

Some Background....

'Saving Mother's Lives':

- triennial confidential enquiry
- Deaths: almost 14/100,000
- Marginal increase:
 - Direct
 - Indirect
 - Coincidental

The avoidable deaths...

- Cardiac – poor diets, smoking, alcohol, obesity
- *“Health professionals unable to identify / manage common medical conditions”*
- *“Poor/non-existent team working”*
- *“The lack of sharing of information...including between GPs and the maternity team”*

Women who died...

- ...stark inequalities....
- ...vulnerable women with socially complex lives:
 - 14% domestic abuse
 - 11% substance abuse: 60% registered addicts
 - 10% known to child protection services
 - Most deprived 5x more likely to die than least deprived (England)
- Black African women: 6x higher risk than white to die

The most vulnerable of all....

- ..were often known to social services
 - Of the 360 existing children who lost their mother, almost a third were already in social services care
 - Some concealed their pregnancies, many avoided antenatal care
 - Social services assumed ‘usually erroneously’ that the woman was receiving antenatal care
 - 41 women died after a child protection case conference
- “Those women who need maternity services most, use them least”*

Lothian Pressures...

- More pregnancies / assisted births / medical complexity / older mothers
- Epidemic of obesity
- More pregnant women born outside the UK
- Socio-economic deprivation
- Inverse care law....
- Less GP involvement in care
- *Secondary care dominance / pressure?*

Our pregnant women:

1 year of booking discussions:

- 163 women
- 21% born overseas
- 6% need translators
- 11% teenagers (18).

Medically:

- 5 hypothyroid
- 3 previous cancers
- 1 Hepatitis C and 1 syphilis
- 2 gestational diabetes

Psychosocial Issues...

Drug Misuse (past or current)	15	One current IVDU. Several on scripts
Alcohol	3	Major
Social Work involvement	18	
Known domestic violence	6	1 in refuge
Eating disorders	5	Several others very low BMI

And several with more serious conditions...

- Stroke
- Bipolar
- And others...

- Many high risk pregnancies obstetrically too.

Family Care....

- Children's clinic
GP, HV, PN

- Antenatal clinic:
 - All appointments post-booking
 - Pre-clinic meeting
 - HV, CMWs, GP
 - Post clinic update

We discuss....

- ALL new bookers:
 - Past history checked in GP records & booking details added
- All other problematic cases
- All deliveries
- Everyone coming to the clinic....
- And afterwards, everyone who has been to the clinic...
- ..or not...DNAs are crucial...

Name Age	Parity	High risk	Drugs/ Alcohol	SW or CPR concerns	Translator required	Other/ EDB	Outcome

A committed CMW team...

- "Established profile in the community...people know you"
- Relationships
- High level of 'automatic' background knowledge of women & their families – risk assessing and sharing
- Skills, experience, knowledge – local and specialised

Multidisciplinary team working:

- "get to know what you don't know"
- Non-judgemental
- Continuity
- Flexible –so brings choice to women who most need it
- Multi-agency for substance/alcohol misuse
- Prepare team – monthly meetings

Systematic Holistic Care:

- Continuity with GP and CMW
- Case discussions
- Systematic approach to risk:
 - Drug misuse
 - Set appt schedule –know DNAs
 - Medical care
- Joint use of GP and hospital records

ANTENATAL CHECK LIST FOR DRUG-USING PREGNANT WOMEN

ACTION	Date	Outcome
Appt with R Hughes		
?Refer PREPARE		
1 st growth scan		
2 nd growth scan		
Other recommendations: •Urine toxicology •Hep C testing		
Case discussion (28/ 40)		
Case Conference indicated?		
Other complications		

Appointment

GP:
 HV:
 SM:
 EDD:

Script details and Prescriber
 Previous children/other household members

Our Obstetrician...

- Visits the practice monthly
- Continuity
- Sees patients
- Meets with GP & CMWs
- Helpful & accessible
- Educational
- E-mails too!

Antenatal services...threats and possibilities?

- Joint records
- Increasing pressures...GP and CMW
- Skill mix and administrative support
- Acknowledgement in QOF or enhanced services – inverse care again?
- Ethnic minority services
- Social Work
- Weighted CMW numbers
- Deprivation Interest Group



Working Together for Vulnerable Children and Families

Margaret Ritchie, Team Leader
 Child and Adolescent Mental Health Service

Child and Adolescent Mental Health Service

The West Centre

Communication

- Improvements within CAMHS, Child Health, Social Work and Education.
- On-call clinician
- Communication with referrers
- Links with adult mental health

Responsive to need

- Direct Access Service
- Urgent /Soon protocol
- Multi-disciplinary team

- Waiting times
- Early Intervention



Working Together for Vulnerable Children and Families

Donna Hunter
Community Paediatric Nursing
Manager

COMMUNITY PAEDIATRIC TEAM

- Community Children's Nursing Team
- Special Educational Needs Nurses
- iCARE
- Mainstream Nurse Specialist
- Specialist Health Visitors (Professional Lead)

WHAT WORKS WELL

- Cohesive team – avoids duplication
- Appropriately trained Health Care Support Workers
- Sit within management structure of both Acute and Community Services

WHAT DOESN'T WORK WELL

- Standard response from Partner Agencies
- Discharge from Acute Services
- Lack of IT support

FUTURE STEPS

- Community Child Health for the 21st Century
- Professional network across NHSGG&C
- Development of End of Life Service
- Continue to communicate within and outwith NHS