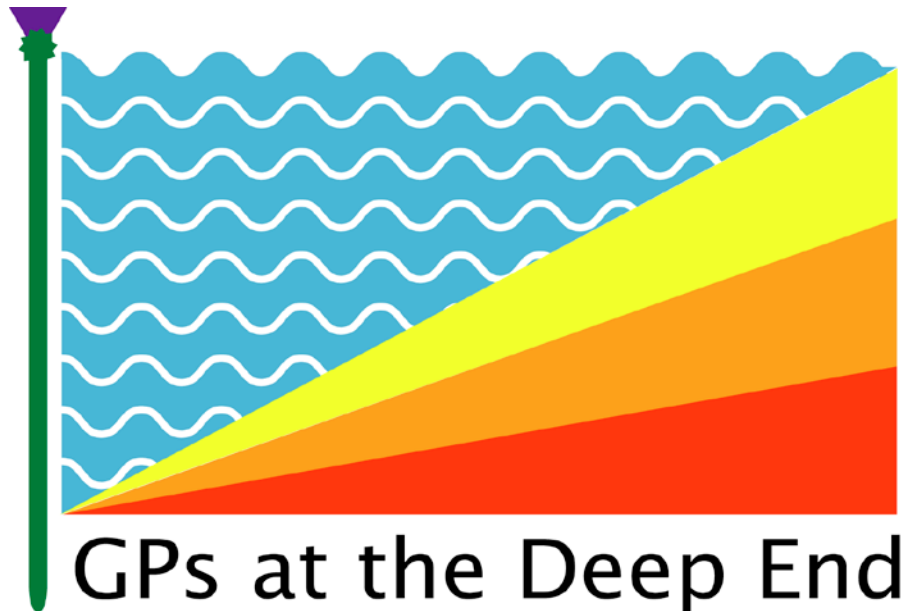


WRITTEN EVIDENCE ON THE CHILDREN AND YOUNG PEOPLE
AND THE PUBLIC BODIES (SCOTLAND) BILLS
FROM



(serving the 100 most deprived communities in Scotland)

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General comments concerning General Practice and the Two Bills from A Deep End Perspective

As a GP the barriers that prevent me working more closely in partnership are excessive workload, uncertainty and anxiety over job security, high turnover of staff, short life span of community projects, bewildering array of services and pathways, lack of time and difficulty in getting hold of people, dysfunctional and overly large planning committees, incomprehensible and verbose communications from on high, abstract rationalist planning that disparages experience and organically developed systems, a remorseless rise in demand and expectations, a self-defeating emphasis on measurable factors that undermines the quality of interpersonal relationships and care.

Deep End GP

General practice is the main public service that is in regular contact with virtually the whole of the general population, with substantial cumulative knowledge and experience of people's problems and consistently reported high levels of public trust. These intrinsic features make General Practices the natural hubs around which integrated care should be based, with groups of General Practices supported, within the context of local service planning, to deliver integrated care in partnership with secondary care, area-based NHS services, social work and community organisations.

The Deep End Report 18 on Integrated Care (Annex A) lists the essential ingredients of an integrated care approach. Attached workers, lay link workers and protected time are keys to joint working. Local leadership needs respect, support and representation (not consultation) within locality planning and acknowledgement of practitioners' experiential knowledge to develop an 'ecology of practice' (Fisher & Owen, 2008).

In front line care the two main barriers to integrated care are firstly, the inverse care law, whereby practices serving the most deprived areas are insufficiently resourced to meet patients' needs, and secondly, poor links between general practices and many other area-based health and social services. These challenges are clearly stated in Deep End Report 12 on Vulnerable Children and Families (Annex B). This report highlights the frustration of practice teams who remain limited in their ability to deal with children with unmet needs in vulnerable family settings. Current policies aimed at family support unfortunately often fail to explicitly outline the contribution of General Practice to child safeguarding.

The policy memorandum for the Children and Young People Bill makes no reference to General Practice, while the memorandum for the Public Bodies only refers to General Practitioners as a group to be consulted. There is no recognition of general practice as the natural hub of local health systems, based on its intrinsic features of population contact and coverage, continuity, cumulative knowledge and trust.

Although many services are involved in caring for children, practice teams often have additional substantial contact with and knowledge of a child's family, including the health of parents and carers, which is relevant to understanding child well-being on a case by case basis. Most GPs recognize and value the continuity with families and possible opportunities for early intervention that should define universal child health care within the primary care structure. This remains an unrealized aspiration at present because the system does not support the full potential of General Practice's contribution towards safeguarding children.

General Practitioners at the Deep End address this concern in Report 20 *What can NHS Scotland do to prevent and reduce health inequalities?*, which advocates for a National Enhanced Service for Vulnerable Families (Annex C), providing a more explicit role and

additional pro rata support for general practices serving vulnerable families in very deprived areas.

Working Outside A Managerialist Framework

Locality planning is not just about commissioning and budgetary planning but about organically growing trust, relationships and local systems that make integrated working and smoother decision-making possible. Front line staff and volunteers are the people who will or will not work as partners to make services more integrated and seamless for patients. However, they need to be given the resources to be able to do this, and not loaded with endless targets developed remotely. I hope this legislation will not be another missed opportunity to create the kind of organisational environment which makes it possible to grow this kind of trust and people-based system of care that patients expect and deserve.

Deep End GP

General Practitioners at the Deep End welcome the different approach in Scotland, from the rest of the UK, which encourages localism, favouring less central control and trusting professionals to work with and shape policy development (Greer, 2005). However, the Joint Bodies Bill appears concerned mainly with a second attempt at the structural integration of current local health and social care organizations. Policy consolidation is not a linear process, as the recent attempt at Community Health Partnerships has shown, resulting in ineffective integrated care for patients and widespread professional scepticism about the new arrangements.

General Practitioners at the Deep End question any assumption that the budgetary and accounting arrangements of senior managers are the key factors in enabling or preventing partnerships. In reality this superstructure rests on a foundation of human factors that are not given sufficient weight in these proposals.

The Joint Bodies Bill only mentions general practice in terms of how general practices working in localities should be represented within the new joint working arrangements. It is also important to consider the essential ingredients of care arrangements providing integrated continuity of care for large numbers of people. At present the opportunities for GPs to engage directly with locality planning arrangements are limited, patchy and inconsistent.

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Specific Questions

Q1. *What benefits which might accrue from shared working arrangements, both for the organisations involved and for those in receipt of services?*

- It is important to acknowledge that despite the consensus that collaboration within health and social care is more effective than single agency approaches there are substantial problems associated with the adoption of this principle.
- Documented problems include a lack of definitional clarity surrounding partnership, endless organisational restructuring and barriers between core and third sector agencies. A general lack of valid evidence of improvement to service delivery and user outcomes means that we know 'relatively little about what works' (Glasby & Dickinson, 2008, p.38)
- It is imperative to acknowledge that policy imperatives can lead to unintended consequences in the delivery of services. The increasing bureaucratisation of managerial systems has resulted, we believe, in fragmentation of health service provision.
- Services that Deep End GPs regard as attached and intrinsic to effective universal and targeted health provision (e.g. midwifery services, pact teams and health visitors) are now professionally and strategically removed from General Practice, resulting in less opportunity to provide a coherent effective health service. There are additional barriers to effective working between primary and secondary that Deep End Report 18 on Integrated Care (Annex A) highlights, especially in relation to the provision of seamless care for the frail elderly population. Within the hospital setting, perverse waiting time targets and financial penalties result in difficulties for vulnerable children who often miss hospital appointments and are not offered second appointments.
- The Deep End Project has outlined how general practice can contribute to the conceptual and theoretical coherence of partnership working, by developing community based solutions, better use of support services and increased patient participation in their own health and well-being.
- Our proposals build on the work already taking place in General Practice where the serial encounter is key to developing holistic unconditional healthcare and where General Practice may be the most suitable setting to promote resilience in communities and empower patients and their carers in managing their health needs (Mola, 2013).
- Collaboration between GPs and other partners exists on many different levels. Working collaboratively promotes a collective determination to reach objectives where sharing information and experiences contributes to a more detailed local knowledge of individual patients and their families. This is vital to planning effective support services for patients, addressing their unmet health needs and anticipating when they will need to access specialized services.

- The complexity of health issues that are a consequence of multimorbidity, beginning earlier in Deep End practice patients, requires informational continuity and continuity of care to ensure that services are best matched to the patient's requirements. The Deep End believes that General Practice is the natural hub of such a health care system partly because of the serial encounter between GPs and their patients and the detailed health information that is held in patient records. If the ethical considerations to sharing sensitive information are explored at the outset of the integration agenda then it is more likely that professionals will be able to better plan patient care that is acceptable to patients.
- We know a great deal about the psychosocial consequences of adverse early years experiences. We also know that a robust primary care health system is important to improving the wellbeing of vulnerable children and their families (Klevens & Whitaker, 2007; Scribano 2010). Given that almost all children and families have a named GP and will consult with their GP regularly we need to promote the role of general practice in supporting vulnerable children. The Deep End has provided a detailed proposal that both clarifies the role of GPs in child safeguarding and describes the structural process to allow this. The legislation if interpreted appropriately, can underpin this process and ultimately General Practice can contribute to better outcomes for vulnerable children.
- If we are allowed to maintain organizational autonomy but promote mutuality between professionals then reciprocity and trust will become embedded into the process. This will build effective teamwork as professionals begin to mutually understand the concepts of 'unmet needs' and 'vulnerability'. The principle underlying collaboration is to improve patient care. In order to do this requires a framework that provides the time required to develop formal and informal means of interaction between professional groups strengthens and stabilizes team working and also makes the lines of responsibility clearer when planning health and social care provision.

Q2 *What is the rationale for having a separate approach in both bills to establishing joint working arrangements?*

- From a GP perspective this is not relevant. In GP consultations in practice or during houses visits we are presented with dilemmas that are resolved pragmatically with practical solutions. What is valuable is having an extensive network of readily accessible interagency contacts when planning the support of vulnerable patients and time to co-ordinate the support package. This may be required immediately or developed over time depending on the patient's circumstances. Joint planning arrangements are strategic processes that should be guided by the frontline professionals and remain patient centred if we are to achieve the aims of the integration agenda.
- Within the context of vulnerable children and families the strategic planning aspect of joint working arrangements should ensure that the options to GPs are

multifaceted. This should be encapsulated within the Children's Plan and recognise that vulnerable children are often sign-posted by general practitioners to supportive services. Most vulnerable children do not reach thresholds of intervention that would trigger involvement of statutory services. The 'targeted' intervention is frequently embedded within the universal provision of child health care in general practice. It is incumbent on the relevant health authority to recognise this important gatekeeper role for general practice as it establishes its role as a 'corporate parent'. The mechanism for GPs to inform this process as it is developed would require the contractual arrangement that the Deep End has suggested in its report.

- In respect of adult services the newly formed 'Integration Authority' must be prepared to canvas GP views widely on the implementation and evaluation of the integration agenda. There should be very direct lines of communication between this body and general practice, other professionals and patients as the changes are implemented.

Q3 *In what areas might potential savings arise?*

- The compelling arguments for greater integration of health are driven by rising demand for service and the need to reduce public expenditure. However, there is a lack of economic evaluation of cost effectiveness across studies (Ellis et al, 2006) therefore the savings remain theoretical and are yet to be realised.
- There are potential savings in adult services for example, if pooled budgets in health and social care genuinely result in less time spent in hospital for elderly patients who can be discharged into nursing homes. It remains unclear however how barriers to transferring savings in secondary into primary care will be removed.
- In children's services savings may result from minimising the consequences of adverse childhood experiences that persist into adulthood. These might include time lost at work through illness and injury, absent school attendance in the short and long term, indirect costs of special education, adult mental health and other healthcare services and the costs to judicial system. Many of these costs savings would be indirectly related to interventions in childhood which would include the proactive identification of vulnerable children in a primary care setting. This would require a different approach to the economic evaluation of such interventions.
- There are not only potential economic savings through the integration of health and social care services. There are intangible savings for example reducing mental anguish and social stigma and are applicable to both adult and children's services.

Q4 *What other issues are there around the proposals covering consultation on, and development of, strategic plans/service plans between the respective areas involved?*

- In adult services irrespective of how the 'integration authority' is realised there should be robust mechanisms that ensure the engagement with frontline professionals who are tasked with implementing the policy. This is challenging to achieve in General Practice but having a GP lead for each locality /practice and an infrastructure to engage widely with colleagues through for example, protected learning events, would ensure that policy directives are meaningfully guided and influenced by local population needs.
- Governance and accountability processes need to be widely understood and transparent to uphold the integrity of the integration agenda and discourage professional scepticism about the contribution of integration of health and social care. There should be clarity about individual and collective accountability at all levels of strategic planning and during each stage of the implementation of the integration agenda.
- Integration of health and social care and its evaluation are long term processes. Both should be evaluated using a robust research approach specifically because there is a lack of a convincing evidence base for integration of health and social care (Cameron & Lart et al 2013). The Deep End in collaboration with the South Glasgow CHP has proposed such a project but this requires a sustained commitment from Government to support the work and allow frontline professionals and patients to participate in the development of the integration agenda.
- Well intentioned reforms must not exacerbate the margin of error when dealing with the complexity of family circumstances with respect to safeguarding children which are often attributed to deficient interagency working and a failure to share information. Standardisation and micromanagement of decision making in situations where evidence can often be ambiguous and contradictory defeats the purpose of having an integrated system because it cannot support complex decision making in its human, social and organisational context. The Deep End believes that a 'light-touch' system design is required whose purpose is not to intensify the bureaucracy of professional working but to free up time, support flexibility and intelligent professional discretion to cope with the contingencies of situations as they arise on a case by case basis. The professionals and patient experience should be driving the development of integrated services, not the system.
- Our faith in the instrumental efficacy of technology and proliferation of process-orientated tasks should not displace what is essential to effective integration working practices, namely sustained professional relationships that are built on mutuality and trust. The Deep End research proposal outlines very clearly the importance of acknowledging the multifaceted aspects of vulnerability and how this maybe inculcated into an agenda that supports professional involvement in

vulnerable patient groups in a meaningful way. For example biological, neurological and psychosocial factors may be relevant to the definition of the vulnerable adult or child but in the context of knowledge sharing between professionals this process is 'slippery' (difficult to codify) and 'sticky' (difficult to share across boundaries) (Reder & Duncan, 2003). Furthermore, acknowledging that non-electronic communication is a component of reaching sound inter-professional agreement (Saario, Hall & Peckover, 2012) is vital to avoid fallacious circular reasoning in complex decision making. If we are to achieve the aims of the integration agenda time must be given to professionals to have regular face-to-face meetings to discuss their own anxieties and share professional opinion in often emotionally and morally charged cases to sustain confidence in their decision making.

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23rd August 2013

ANNEX A : DEEP END REPORT 18 (See www.gla.ac.uk/deepend)

INTEGRATED CARE

This report and recommendations draw on research evidence, previous Deep End reports and discussion groups at the second national Deep End conference at Erskine on 15 May 2012.

- To avoid widening inequalities in health, the NHS must be **at its best where it is needed ost**.
- The arrangements and resources for integrated care should reflect the **epidemiology of multimorbidity** in Scotland, including its earlier onset in deprived areas.
- Better integrated care for patients with multiple morbidity and complex social problems can **prevent or postpone emergencies**, improve health and prolong independent living.
- Policies to provide more integrated care must address the **inverse care law**, whereby general practitioners serving very deprived areas have insufficient time to address patients' problems.
- Patients should be supported to become more **knowledgeable and confident** in living with their conditions and in making use of available resources, for routine and emergency care.
- The key delivery mechanism for integrated care is the **serial encounter**, mostly with a small team whom patients know and trust, but also involving other professions, services and resources as needs dictate.
- The intrinsic features of general practice in the NHS, which make practices the **natural hubs of local health systems**, include patient contact, population coverage, continuity of care, long term relationships, cumulative shared knowledge, flexibility, sustainability and trust.
- Health and social care professionals working in area-based organisations (e.g. mental health, addiction and social work services) should be **attached to practices**, or groups of practices, on a **named basis**.
- Practices should be supported to make more use of community assets for health via a new lay **link worker** role.
- The quality and timeliness of hospital discharge information should be a consultant responsibility and audited as a **key component of the quality of hospital care**.
- Practices needed **protected time** to share experience, views and activities, to connect more effectively with other professions, services and community organisations, to develop a collective approach and to be represented effectively.
- **Collective working** between general practices is best achieved with groups of 5/6 practices, as shown by the Primary Care Collaborative and Links Project. Larger groupings are less likely to achieve common purpose.
- **Locality planning arrangements** should be based on representation (not consultation), mutual respect and shared responsibility.

ANNEX B : DEEP END REPORT 12 (see www.gla.ac.uk/deepend)

WORKING TOGETHER FOR VULNERABLE FAMILIES AND CHILDREN

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.

- 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.

ANNEX C : From Deep End Report 20

WHAT CAN NHS SCOTLAND DO TO PREVENT AND REDUCE INEQUALITIES IN HEALTH?

Vulnerable children and families

Current thinking

It is uncontested that vulnerability in early years and beyond impacts adversely on child and adult physical and psychological dimensions of well-being. [1–2] A conservative estimate of the economic cost of the vulnerable child to society in the UK is £735 million annually [3].

Where is general practice?

The Deep End manifesto and reports on vulnerable families [4–5] clearly outlined the contribution that general practice can make to safeguarding children and families. GPs contribute to the process of ongoing family assessment and support [6–7] and are well placed to understand the specific challenges that result in the vulnerable family and the vulnerable child [8].

A skilled and long term professional relationship, built on trust, that provides a low-level of inquiry into the circumstances of the vulnerable family [9] is key because vulnerable parents are often avoidant and suspicious of supportive services [10]. Furthermore, the majority of vulnerable children will not meet sufficient thresholds of harm or endangerment that will trigger formal child protection proceedings [11].

The Deep End has consistently highlighted the ‘multiple jeopardy’ that economically poor and disadvantaged families face [12] with poverty an enduring characteristic of families who would be considered vulnerable. The Deep End recognises the clear association between disadvantage with social class and adverse effects on child health in the first 10 years of life [13] with increased mortality rates [14]. The impact of poverty and the accumulative effect of negative factors on health outcomes of vulnerable children are highlighted in the Deep End Austerity Report [15]. This publication contextualises current research concerns to real-life narratives of vulnerable families who are living within the constraints of swingeing cuts across health and social care budgets.

That said, knowing and stating our contribution to supporting children and families is of limited value if general practice does not have the strategic support within policy directives and contractual obligations to undertake this challenging area of health care.

Current policy – is it collective and inclusive?

Whilst we welcome the acknowledgement of the role of the GP in Scotland’s national child protection framework [16] and the RCGP child health strategy [17] this is not replicated in other important policy directives. For example GIRFEC, whose ethos is at the heart of government policy in ensuring that all children in Scotland are ‘safe, healthy, achieving, nurtured, active,

respected, responsible and included' [18–19] and the National Parenting Strategy [20], do not mention GPs. This is disappointing given that the newly instated 30-month child development check will address issues of 'child development and physical health, parenting capacity and family matters including domestic abuse and parent-child relationships, along wider parental health such as smoking, alcohol or drug abuse, and mental and physical health' [20]. It is obvious to the Deep End group where the obligation to general practice provision lies in addressing this agenda.

Given that there has been a noticeable decline in preventative child health care in general practice since the implementation of 'Hall 4' [21], the Deep End have advocated for a National Enhanced Service for Vulnerable Families (NES). This approach will not diminish the reach of a universal child health care system but recognises the need to reduce disadvantage in vulnerable families by developing services according to the needs of the community.

How would the proposal work, both internally within practices, and externally in practices' relationships with others?

The NES is a collaborative model that promotes organisational learning where all involved professionals meet regularly to discuss their vulnerable children caseloads.

It is hypothesised there would be immediate gains in terms of improved health outcomes and consistent support for vulnerable children.

The NES would build on the work that is already done in some GP practices where GPs have regular and minuted meetings with their health visitors but it remains 'unofficial' as there is no contractual requirement to do so. Across practices the NES could be the basis of a protected learning event to disseminate results (similar to the COPD pilot in the South Glasgow CHP) and would include other relevant professionals in the learning agenda.

The attached social worker is not a new idea for general practice and many practices have positive experiences of working with a named social worker across health and social care domains. It would seem axiomatic that the unmet needs of vulnerable children and families require that both professions collaborate but there is a paucity of evidence of effective practices in complex families where health and social care professionals have intervened [22].

The NES provides the mechanism to improve a positive working environment where professional roles are clarified and shared understanding of the language of vulnerability is achievable. It also begins to address a pressing need to meaningfully research the complexity of child welfare outcomes in 'real world' situations [23].

How would progress be consolidated, with practices learning from each other?

A rolling programme of protected learning events funded through the CHP structure. There is a learning coordinator within each CHP (these appear to be new posts but are welcome if they have this remit). Of equal importance is recording the long term outcomes of vulnerable children that would require substantial investment in preventative health care and would provide a robust research database.

How would individual practices and groups of practices be accountable for the additional resource?

At present there is no mechanism for GPs within CHPs to be directly responsible for monies spent. Financial sector spending would have to be carefully evaluated with appropriate management support and would require robust accountability and governance structures.

Is the proposal for all practices, with each being resourced pro rata according to need, which could be taken forward within local areas; or something for Deep End practices only, requiring a network approach?

This would not be exclusive to Deep End practices as the NES is embedded within the principles of universal health care for children. Realistically, it would be anticipated that the strong influence of poverty on child health outcomes and vulnerability would ensure a greater proportion of vulnerable children would be identified within Deep End practices. Nonetheless, the NES would be relevant to all practices in Scotland.

Who are the significant partners/funders and how can they be influenced?

SG, HBs, health and social care professions. There is an expectation that SGPC and the BMA will acknowledge the call for greater emphasis on child health matters within the forthcoming contract negotiations. This would reflect the profession's aspiration for an improvement to the structure of child health care provision in general practice and primary care. This is envisaged under a broader approach of child safeguarding that at present remains patchy and inconsistent.

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