

# GPs and primary healthcare teams: learning from case reviews

## Summary of risk factors and learning for improved practice for the health sector

**August 2015**

General practitioners (GPs) and primary healthcare teams are best placed to spot the early signs of child abuse and neglect. They have an overview of issues affecting individual members of a family which, in combination, may impact on a child's welfare. They are also in a position to co-ordinate the work of different agencies supporting children and families.

### **Reasons case reviews were commissioned**

This briefing is based on case reviews published since 2013 which have highlighted lessons for GPs and primary healthcare teams to improve safeguarding practice.

In these case reviews, children died or suffered serious harm in a number of different ways:

- non-accidental injuries
- [physical](#) and [emotional neglect](#)
- [suicide](#).

### **Key issues for GPs and primary healthcare teams in case reviews**

The case reviews highlighted examples of good practice, for example effective information sharing amongst health professionals and across agencies.

However, the case reviews also highlighted a number of issues for learning.

#### **Having a family focus**

GPs should be the 'lynch pin' in the network of services working with a family. They are best placed to get an overview of the issues facing a family and how these might impact on their ability to care for their children. Case reviews found that some GPs were not recognising the social aspects of a case and did not have a sense of problems accumulating within a family which posed a threat to children.

The case reviews uncovered a number of reasons for this difficulty in seeing the bigger picture:

- A system of accountability for primary healthcare which focuses too much on measurable disease outcomes rather than on holistic health and wellbeing outcomes.
- Complex family structures: family members with different surnames and addresses and adults who have a number of relationships.
- A move towards larger practices with a number of full and part-time GPs and a range of services. This has affected continuity of care because individual patients are seeing a larger number of healthcare professionals.

### **Challenging parents and hearing the child's voice**

Although it is very rare, parents can sometimes be deceptive or manipulative when reporting children's health problems. In some cases, professionals were relying exclusively on parents' reports without examining the child or observing his or her behaviour. Repeat prescriptions were also issued by administrative staff over a long period without the doctor seeing the child. It is important to gather the views of children and other family members, particularly if one parent is particularly dominant or assertive.

Case reviews also highlighted professionals' reluctance to challenge parents' views or probe for further information for fear of provoking a confrontation.

### **Following up missed appointments**

Children rely on their parents and carers to take them to medical appointments so missed appointments are always a cause for concern. Failure to attend medical appointments is recognised as a child protection issue within statutory definitions of [neglect](#). It may also suggest that services are difficult for vulnerable families to access.

Serious case reviews criticised the practice of simply recording missed appointments, but not analysing the records for patterns and trying to find out why a child might be missing appointments. They criticised the system of flagging non-attendance at medical appointments as Did Not Attend which in some cases actually leads to a withdrawal of services. The Did Not Attend category does not recognise the real issue which is children not being taken to appointments, a potential indicator of neglect.

### **Sharing information and working with professionals in other agencies**

Most serious case reviews flag the issue of inadequate information sharing and ineffective work with colleagues and other agencies.

The knowledge held by an individual practitioner or agency may not, on its own, appear worrying but when collated the overall picture may indicate a more significant level of concern and risk. Practical barriers to information sharing include using different and incompatible IT systems or even paper systems; and diverse interpretation of policy, procedure and protocol which prevent effective information sharing.

A number of SCRs identified GPs' uncertainties about levels of concern that should prompt a referral, and also how to escalate concerns when a referral has been dealt with inadequately. In some cases there was reluctance on the part of health professionals to challenge social workers on the presumption that they know best, as well as a tendency to give up and not persist in flagging 'niggling concerns' because of the difficulties and complications of multi-agency work.

### **Out of hours services**

One case review highlighted the issue of out-of-hours doctors being unable to contact family GPs for guidance to inform safeguarding decisions. There was also no follow-up to reassure the out-of-hours doctor that the family GP had acted upon his recommendations.

## **Learning for improved practice**

### **Having a family focus**

- Find out about each patient's family details and their links to children, record these and tell other agencies when this is relevant to assessment of need and provision of services.
- When dealing with mothers, it is particularly important to make regular enquiries about male partners who may have access to her children.
- When seeing parents and carers of children, make routine enquiries about [drug and alcohol use](#) and [domestic abuse](#).
- Always ask patients with mental health difficulties, learning difficulties or drug and alcohol misuse whether they have significant child care responsibilities. Consider their capacity to care for children safely. Record this information in medical notes and emphasise it in referrals and correspondence about patients.
- GPs who work with different members of the same family need to share information with each other on a regular basis.
- Explore how continuity of care can be improved by individual patients and members of the same family seeing a smaller number of different GPs and healthcare professionals.

### **Responding to missed appointments**

- Always follow up a child's missed appointments. Consider changing the non-attendance code from Did Not Attend to Was Not Brought which should prompt more positive intervention to safeguard the child and support their wellbeing.

### Listening to and seeing the child

- Do not automatically accept a parent's or carer's report without talking to the child and if possible other family members and/or close friends. If the child is very young observe and interpret their presentation and behaviour.
- When referring children to acute clinicians, highlight anything that has only been reported by adults or has not been observed by professionals.
- Be alert to patterns in parents' and children's behaviour.
- Do not administer repeat prescriptions to children without a GP regularly examining the child. Consider implementing an alert system to identify the over-prescription of drugs to a child.
- Be prepared to challenge parents and carers in order to gather as much information about a child's wellbeing as necessary.
- Provide training for staff which models effective challenge and gives staff the confidence to inquire into potential abuse.

### Recognising child abuse

Always be aware of the significance of [bruising on babies](#) who cannot move around by themselves. Refer such cases to children's social care with full and accurate information which includes a medical and social history, the child's developmental stage and the explanation given by the parent.

### Out-of-hours services

- Be prepared to communicate with out-of-hours GPs in order to provide them with the information they need to weigh up risks posed to a child.
- Follow up any recommendations made by an out-of-hours GP with respect to a child quickly and inform them of outcomes.
- Out-of-hours practitioners need to be aware of and comply with safeguarding training requirements. Training provided should not only cover the principles of safeguarding but practical examples of what GPs on call need to do in specific scenarios.

### Working with other professionals

- Ensure there are policies and procedures for challenging professionals in other agencies who are not responding adequately to concerns about a child. Perseverance may be needed in such situations.
- GPs have the best overview of all services involved with a child and their family – they are also best placed and have the professional authority to demand a coherent response from all agencies involved.
- When making referrals to children’s social services and other agencies, make sure that referrals are clear and concerns are spelt out robustly. Remember other child protection professionals will not necessarily have an in-depth understanding of the medical issues.

### Effective information sharing

- GPs should automatically share their records with health visitors as well as vice versa.
- If a GP cannot attend a child protection conference they should ensure that another member of the primary health care team attends and is able to represent the GPs’ views and experiences.
- One case review highlighted the good practice of one regional health care partnership which was introducing a single electronic patient recording system to which all professionals working with a patient could contribute.
- Health commissioners should ensure primary health care teams have access to prison health records and court reports to identify adults who may pose a risk to children.

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