**Establishing Links Between Education and Primary Care to Promote Attendance in Schools.**

**A pilot study between School and GP practice Medical Practice.**

**Introduction**

Collaborative working has been the lynch pin of safeguarding legislation since the introduction of the Children’s Act in 1989. There have been numerous statutory and non-statutory papers and guidelines published to consolidate working together in the best possible manner to protect children.

**Table 1: Benefits and Challenges to Collaborative Working.**

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| **Benefits** | **Challenges** |
| Improved co-ordination of services resulting in better relationships, improved referrals and the addressing of joint targets | Communication – ensuring clear routes for two-way communication between the educational setting, agencies and practitioners in order to exchange information and improve joined-up co-ordinated working. |
| Helps to improve understanding and raise awareness of issues and agencies, and other professionals practice | The danger of a lack of clarity arising about the roles and responsibilities of practitioners in a wider and more diverse children’s workforce. |
| Increased level of trust existing between partners/providers in relation to everyone knowing each can and will deliver | Understanding each others professional language and protocols. |
| Benefits teachers understanding of multi-agency practitioners activities, and knowing about the services to signpost pupils to, enabling them to focus on their core role of teaching | Engaging the ‘hard to reach’ parents/carers, families, children and young people with multi-agency service provision, education and lifelong learning |

Pilot surgery was in the Western suburbs of Liverpool and has a practice population of 7,662. 30.5% of the practice population are children (patients registered at the practice aged 17 and under). The area is classed as a high deprivation area locally and the community faces numerous challenges such as unemployment, low income families, a high rate of chronic child health problems and a high rate of mental health disorders.

Poverty has a significant impact on the educational experience and attainment of many children growing up in the UK.

Gottfried found there is a strong statistical link between absenteeism and underachievement.(6) A government study shows that 5% of pupils with the lowest overall absence rates are five times more likely to achieve 5 or more GCSEs or equivalent at grades A\* to C than the 5% of pupils with the highest overall absence rates.(7) The academic literature is very clear that differences in the social background of pupils are the primary factors causing inequalities in educational outcomes.(8)

Nationally the overall absence rate for the academic year 2017/2018 has increased since 2016/2017 – one in 9 children is now classed as persistently absent. The overall absence rate for pupils in secondary school is 5.5% where 2.9% of these absences are attributed to illness. The percentage of students who are classed as persistently absent is 13.9% nationally.(9)

Non attendance at school is one of the greatest challenges that schools in Liverpool face, with an overall absence rate of 6.2% (0.7% higher than the national average.) Liverpool has a rate of 16.7% for persistent absenteeism (3% higher than the national average.)(9)

In 2018 a secondary school and medical practice in this area embarked on a liaison project with the aim of better communication between schools and general practice and improving attendance at school as part of their commitment to The Attendance Charter. The Attendance Charter is part of the Liverpool Attendance Strategy. This strategy is linked to an attendance action plan which has identified key priorities for the city and will be delivered over the next two years. The Liverpool Attendance Charter states that as agencies, we will work together to support and improve educational attendance of our children across the city of Liverpool, wherever the children live.

The General Practice and Education Link project was led by the Head teacher at School and the Safeguarding Lead for the Medical Practice

**Aim of Pilot Study**

To design a framework to follow to enable a streamlined channel of communication between education and primary care with the aim of improving attendance rates.

**Objectives**

Improving overall communication between school and general practice  
Establishing a strategy for the safe sharing of information regarding attendance rates of pupils  
Providing a framework to follow when receiving notifications of poor school attendance  
Establishing a protocol for safeguarding lead to follow to offer support to children and their parents/carer and improve school attendance rates.  
Working collaboratively with school to promote the importance of school attendance and assist with complex cases.

**Method, Outline Plan and Monitoring.**

| **Aim** | **Objectives** | **SMART objectives** | **Outline Plan** | **Detailed Plan** | **Time frame** | **Monitoring** |
| --- | --- | --- | --- | --- | --- | --- |
| **To design a framework for participants to follow to enable a streamlined channel of communication between education and primary care with the aim of improving attendance rates to an aspirational 97% across the city in the next 2 years.** | Improving overall communication between school and general practice | S - Design a framework for Liverpool general practices to follow enabling them to streamline communication between school and primary care and a protocol for monitoring children with poor school attendance | Pilot study to take place | Letters to be designed for school to send out to practices informing them of poor school attendees registered at the practice | 3 month | Meeting with School Head, CCG, Safeguarding lead on half termly basis. Email monitoring of progress with updates. |
| Establishing a strategy for the safe sharing of information regarding attendance rates of pupils | M - the cost of the protocol is free to all GP surgeries, the personal cost to me is my time in meeting with schools, the LMC and liaising with the CCG. | Letters to be designed for practices to send to parents regarding poor school attendance |
| Providing a framework for general practices to follow when receiving notifications of poor school attendance | A - to achieve this regular meeting need to be set up with school, the CCG and Safeguarding Leads. A pilot study is to be run to assess the impact of liaison on school attendance. | Feedback collated from letters | Audit feedback from letters |
| Establishing a protocol for safeguarding leads to follow to offer support to children and their parents/carer and improve school attendance rates. | R - GP practices have a mandatory responsibility to safeguard children. Identifying risk factors for safeguarding is an integral part of this. Non attendance at school is a risk factor for poor outcomes in life so if practices are given a protocol to follow this will improve their safeguarding performance at CQC level and impact on patient safety. | Regular meeting between School/practice/CCG/ Safeguarding Leads | List of safeguarding Lead to be given to all schools with contact details | Every 2-3 month throughout study | Email progress updates to be sent to all involved |

**Appendix 2 cont.**

| **Aim** | **Objectives** | **SMART objectives** | **Outline Plan** | **Detailed Plan** | **Time frame** | **Monitoring** |
| --- | --- | --- | --- | --- | --- | --- |
| ***(continued)*** | Working collaboratively with schools to promote the importance of school attendance and assist with complex cases | T - It will take up to 3 months to run the pilot study and prepare a pilot study paper for presentation to the LMC. |  | School to use software system to generate poor attendee list for sharing over secure network |  | School to monitor progress of software |
| Pilot study paper to be prepared for the LMC | Input from school and practice | 3 months | Drafts to be discussed at meetings |
| Presentation to LMC | Liaison with LMC secretary | Dead line June/July | Preparation with LMC member before meeting |
| Presentation of framework for practices to follow |

**Results from Pilot Study.**

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| --- | --- | --- | --- |
|  | Total | Male | Female |
| Number of patients identified | 29 | 15 | 14 |
| Number with a medical reason for poor attendance | 20 | 11 | 9 |
| Number with a parent with mental health problems | 15 |  |  |
| Number with parents with alcohol dependence history | 3 |  |  |

All 29 children had a letter sent to their home address notifying them that school had contacted the GP surgery with their attendance rate, we had reviewed the notes and could/could not see a medical reason for this. All children/parents offered an appointment to discuss this further at their convenience. All children identified with a possible medical reason encouraged to share this with school.

After a two week period all parents were contacted via phone who had been sent a letter. Phone calls were made on three separate occasions.

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| --- | --- | --- |
|  | **Total** | **Percentage** |
| Response rate for feedback | 21/29 | 72.40% |
| Number with medical reason for attendance after final review of records and feedback | 23/29 | 79.30% |

**Discussion of Feedback.**

29 pupils were identified as patients of GP from the figures sent over by school with a pretty even split of male (15 patients) and female (14 patients) . When the notes were reviewed it was thought that 69% of these pupils had a possible medical reason to account for absence from school. These reasons included menorrhagia, mental health problems eg anxiety, overdose, recurrent infections eg tonsillitis, ear, behavioural problems eg school refusal, operations and musculoskeletal problems eg fractures and bone cysts.

It was thought that the parents health could potentially impact the attendance rate of their children so a quick review of parent medical records was also undertaken and it was found over half of the parents with a child with poor attendance suffered with mental health problems, namely anxiety and depression.

After letters were sent to all children on the list follow up phone calls were made to parents/guardians. Follow up phone calls took place on three different dates and where there was no reply up to three attempts were made to contact the parent via phone. No messages were left however as there was no guarantee when a parent phoned back I would be able to speak with them. 72.4% of parents were contacted and out of these 14.3% said they had not received a letter from the practice but were happy to speak over the phone about their child’s attendance.

Overall feedback was generally positive. Over half the parents spoken to felt the letter provided good supporting evidence for them to give to school. Nearly 43% said they were pleased to receive a letter showing schools and GPs were communicating with each other and 48% thought it was a good idea to improve the communication between GPs and school. Parents felt the letters provided a talking point for them to start a conversation with school about attendance and work with school in getting their children to class. Some parents were unaware of some of the services that school offered such as breakfast club so felt they could now access this. Parents also commented they felt it was great the GP was taking an interest in their child and that they felt supported with the medical problems their child had. All parents felt they had a better relationship with their GP after the follow up phone conversation.

8 out of the 21 parents spoken to were originally annoyed to have received the letter from the GP practice. The main issue was that they thought school had contacted the GP practice asking for medical information to explain why their child hadn’t attended school. Other feedback stated they were annoyed with school telling the GP of poor attendance as they had already discussed it with school themselves so didn’t see why school had shared the information or had spoken to school about absences already and then received the letter from the GP practice after they thought the matter had been resolved. Here poor timing and co-incidence was the issue.

This highlighted issues with communication between school and parents and also the clarity of the letter sent by the GP practice. One parent suggested school should let parents know they were notifying GP practices of attendance rates. Another parent fed back that the letter sent to parents from the GP practice needed to be more explicit in explaining what school have notified and reassure parents that no confidential medical information has been requested as there was an assumption this was the case.

Other feedback from parents highlighted an alleged lack of awareness of staff at school about the School/GP project where apparently one teacher said they had no knowledge that school was letting GP practices know about poor attendance and there was another miscommunication by a teacher to a parent that it was mandatory to let the GP know of poor school attendance.

Of note three children who had received a letter stating there was no medical reason noted for absence actually did have genuine reasons for being off. Two cases were where the pupils had been under hospital but this had not been coded on receipt of hospital letters to the practice, and another child had been off with anxiety due to bullying that school was aware of but the GP was not. This highlighted the issues with reading and coding hospital letters by clinical staff and where a better channel of communication between GP and school could have identified the child with anxiety.

A review of attendance of the same group of patients after the letters and feedback showed a 3% increase in attendance rate in 58% of the patients originally identified. A quarter of the students originally identified were now no longer classed as persistently absent as their attendance had improved over 90%.

**Summary.**

School and GPs need to improve the way they communicate with each other and parents, to improve school attendance rates. In general most parents see liaison between schools and general practice a good thing and are willing to engage with this process to support their children attending school.

Communications from school to parents, and GPs to parents need to be explicit in explaining what information is being shared and reassure parents that confidentiality is being maintained.

School need to cascade information to all staff so they are aware of liaison between schools and general practice so they do not miscommunicate to parents. General practice needs to ensure important diagnoses and clinical information is coded corrected on patient notes as this information could prove valuable if there are queries from schools, safeguarding or parents for absenteeism.

A better channel of communication between school and general practice regarding pupils who are bullied would be helpful to ensure support services are in place for both the child and their family and deal with any mental health sequelae that may arise.

**Recommendations for Best Practice.**

Education and Primary Care should agree to work together, with better communication channels in place, to identify and discuss at-risk children early.

Schools should be provided with the name of the designated lead for safeguarding at each practice and a secure practice email address so any concerns had be communicated securely and in a timely manner. Where possible a direct phone number could be provided so schools and GPs can bypass the generic reception/office queue when trying to communicate with each other.

**Competing interests.**

None declared

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