DfES/DH Research Project

The Child, the Family and the GP:
Tensions and conflicts of interest in safeguarding children

May 2006 to October 2008

Document 2

Appendices to Final Report February 2010

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Document 2 – List of Appendices

GP QUESTIONNAIRE

Date: October 2006

Thank you for agreeing to complete this questionnaire. If you wish to expand on any of your answers or make any other comments please do so on the last page of this form.

Gender: Ethnicity:

Special interest (*if any)* .....

Number of GPs in Practice:

How long have you been a GP?

Less than 5 years: ☐ 5–10 years: ☐ 11–20 years: ☐
21–30 years ☐ 31 years + : ☐

PLEASE TICK THE CORRECT BOX

	Yes	No
1. Have you had any Child Protection training since January 2003?	☐	☐
a) if yes:		
i) Was this training for primary health care workers only?	☐	☐
ii) Was this multi agency training with staff from other agencies such as Social Services?	☐	☐
iii) Did the training cover issues of confidentiality?	☐	☐
iii) Did the training cover how to deal with GP concerns within a consultation with the child and parent?	☐	☐
2. **If you were confronted with a complicated problem during a surgery consultation where you felt that a child may be at risk:**	☐	☐

a) What would you do in the first instance?

b) Would you follow Child Protection procedures and if so what steps would you take?

c) Which other professionals and agencies would you contact?

d) How would you contact them?

Phone ☐ Email ☐ Letter ☐ Face to Face ☐

Other: …….

e) How soon would you do this?

Less than 24 hours ☐ Between 24 and 48 hours ☐ Over 48 hours ☐

f) What problems do the Child Protection procedures and guidelines raise for you as a GP?

Yes No

g) Have you ever been in a situation where you have found the Child Protection procedures inadequate or counter productive? ☐ ☐

Please explain

3) **Have you ever been in a situation where you have found the Child Protection procedures inadequate or counter productive?** ☐ ☐

Difficulty	Not normally concerned	Slightly concerned but would take no action	Concerned enough to address this with the parent	Concerned enough to request monitoring with health worker	Serious concerns leading to referral to Social Services
Mental health problems					
Alcohol/Drug abuse					
Domestic violence					
Poor standard of living					
Learning disability					
Physical disability					
Cultural factors					

4) **Which of the following would cause you concern about a child's safety?**

Presentation of Child	Not normally concerned	Slightly concerned but would take no action	Concerned enough to address this with the parent	Concerned enough to request monitoring with health worker	Serious concerns leading to referral to Social Services
Withdrawn					
Neglected					
Anxious					
Injury					
Failure to thrive					
Behavioural problems					
Repeated presentation at surgery					

5) Who would you consult if you had concerns or suspicions that a child was being abused?

.....

6) If you had concerns that a child may be at risk of significant harm would you:

(Please tick all that apply)	Yes	No
a) Discuss this with the parents but not take any further action?	☐	☐
b) Talk to the parents and seem their permission to refer to:		
i) The Health Visitor	☐	☐
i) Social Services	☐	☐
iii) Other (please specify)	☐	☐

c) Talk to the parents and seek their permission to refer to:

i) Take no further action ☐ ☐

ii) Ask the Health Visitor to monitor ☐ ☐

iii) Contact Social Services ☐ ☐

ii) Other (please specify) ..... ☐ ☐

d) Not discuss with the parents/carers but ask for the opinion of a paediatrician if you were not sure but suspected harm? ☐ ☐

7) Please describe the practical constraints that you encounter when dealing with a child about whom you have concern.

8) What difficulties do you experience in coming to decisions about safeguarding children?

Yes No

9) Have you ever been invited to any Child Protection conferences in the last 12 months?

a) Did you attend? ☐ ☐

a) Did you provide a written report? ☐ ☐

c) If you were invited and did not attend, or did not provide a report please could you briefly explain your reasons?

10) If Social Services have requested information about a child subject to a child subject to a risk assessment (s47):

Yes No

a) Did you provide this? ☐ ☐

b) Could you briefly explain what issues the sharing of information with other agencies about children raises for you as a GP?

	Yes	No
c) In terms of confidentiality did this request cause you any dilemmas?	☐	☐
d) If yes, please briefly explain:	☐	☐

e) I have never been asked to provide this information. ☐ ☐

11) How often in the last 12 months have you experienced a dilemma in terms of confidentiality and information sharing with regard to safeguarding childeren?

Never ☐ 1–3 times ☐ 4–6 times ☐ 7–10 times ☐ more than 10 times ☐

12) Can you think of an example where confidentiality or conflict of interest issues may have put a child at risk or resulted in harm to a child?

Thank you for completing this questionnaire. If you wish to make any additional comments please add them at the bottom of the following page.

INTERVIEWS

We would like to interview approximately 30 GPs to explore experiences of problematic 'conflicts of interest' cases and the issues these raise (how they are managed, the outcomes etc.), and the GP's reflections on these cases.

I am willing to take part in an interview **Yes / No**

If you are willing to take part in a follow up interview please complete the contact details below along with the enclosed consent form.
A member of the research team will then be in contact with you.

Name:……

GP Practice Address:

……

……

……

……

Contact Phone

No:…….

Email:…….……

Additional comments.

Please use the back of this sheet for further comments if necessary.

Appendix 2 – Sample GP Interview Schedule

Sample interview with GP -individual interviews were modified to take account of responses in the GP questionnaire.

Clarify current role – then issues from their questionnaire

1. One of few that have had training - (Health and Multi). We are picking up that many GPs have not had training since 2003. QOF – do you think aspects of CP work (training) could become targets?
2. Pathway – you say not realistic in procedures -you tend to go to Health colleagues first – do you think this is okay in terms of CP procedures?

   Would you go direct to police?
3. SSD response -you express concerns about this – comment further

   How do you feel this could be improved
4. Decision Making -Mention difficulty in decisions as no one to discuss with.
5. Information sharing – could you give an example to where sharing information with family has been raised difficult issues/dilemma for you?
6. CP conference -Do you have views about GPs involvement in Case Conferences and provision of reports?

GP role
How significant do you feel the GP is in safeguarding children?
Do you think you (GPs) know their families well?
Do you feel other agencies have realistic expectations of you?
Health Colleagues
Importance of HV -is this affected by declining numbers/ change in structures?
Would you tend to consult within Health before SSD?

Experience of CP issues with children with disabilities and ethnic minorities

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2 scenarios.

A 13 year old girl presents at the surgery and discloses that she has been having a sexual relationship with a family member for 2 years and is worried she might be pregnant. She says she only wants advice about abortion and does not want any other intervention.

Young mother from an ethnic minority with 2 pre school children presents at the surgery to say she is not coping. She has a history of depression and says she feels like killing herself. She tells you she has planned how to do it. When you suggest referring her to other agencies she refuses permission saying she would be wasting your time.

Appendix 3: Key Stakeholder interview schedule

Introduction (*5mins)*

This study is looking at Conflicts of Interest for GPs in safeguarding children To do this we need to gain an understanding of the GP's role within the multi-agency context and to be able to identify how other professionals see this. We would, therefore like to ask you a series of questions covering

1. Your own role in safeguarding children
2. Your expectations of the GP and the significance of GPs in CP
3. The GP's role
4. Information Sharing
5. Training

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1. Basic details *(5mins*)

a) Gender, ethnicity, position held, organisation, length of time in post

b) Could you briefly describe your role in relation to safeguarding children and the LSCB?

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2. Expectations of GPs (*10mins)*

a) Could you tell me what your expectations are of GPs in safeguarding children?
   b) Do you feel this is reflected in the multi agency procedures?
   c) Do GPs have their own procedures as to how to deal with CP issues?
   d) Could you give an example of where you feel GPs have worked effectively within an interagency context to safeguard children? e) Could you give an example of where you feel the GPs have not met your expectations and the requirements of the multi agency procedures?

3. Significance of GPs

a) How significant do you think the role of the GP is in safeguarding children?
b) Can you give any examples of this and comment on the actions of the GP?

---

4. The role of the GP…… Thinking about the role of the GP *(15 mins)*

a) How able do you feel GPs are at identifying possible CP concerns, addressing these with the parents and referring on to the appropriate agency?
b) How aware do you feel GPs are of the safeguarding needs of children with disabilities and children from ethnic minorities?
c) What constraints do you feel GPs experience in safeguarding children?
d) Do you feel there are conflicts of interest for the GP when dealing with a child/parent?
e) Could you comment on the involvement GPs have in multi-agency meetings about children at risk?
f) Could you tell me what you feel the GPs ongoing role should be where children have been identified as being at risk?
g) Could you give an example of where you feel the GP has taken an effective role?
h) Could you give an example of where you feel the GP role has not been as proactive as you would like?

5. Information sharing (*5mins)*

a) Thinking about the different organisational layers of multi agency working (senior level, middle management and front line) could you describe the key information sharing forums for each and the frequency of contact?
b) Are GPs represented and do they participate in each level?
c) Do you feel information sharing between agencies in your area works well?
d) Could you give an example of areas that could be improved?

6. Training and joint working (*5mins)*

a) How important do you think multi agency training is to collaborative working in safeguarding children?
b) Could you comment on the involvement of GPs in this training and tell me how it impacts on interagency working in your area?

7. Any other comments?

Could ask for them to identify key documents to look at.

Appendix 4 – Focus Group plan and vignettes

Plan for focus groups -young people, parents and carers of young people, South Korean group

Introduction

1. Aims of study
2. Confirmation of consent. Opportunity to withdraw at any time
3. Ground rules
4. Key areas for discussion
   - consent/confidentiality
   - what should a GP do if he has concerns about a child?
   - experiences of contact with GP

Questions to facilitate discussion

Basic Principles

1. When you go to the doctor do you expect the GP to keep what you say confidential?
2. Can you think of circumstances where you would not expect them to keep what they are told confidential?
3. If the GP is going to break confidentiality how should he do this?
   a. Should he ask permission first?
   b. What should he do if he does not get permission?

GP concerns

1. Do you think GPs are aware of things that might make it difficult for a parent to look after children?
2. Do you think GPs give enough attention to the child when a parent takes him for an appointment? Would they pick up any concerns?
3. If the GP is worried about a child what should he do, who should he contact, does he need permission to do this, what if he does not get permission?
4. Who is the best person to help a parent and child where there might be concerns?

Vignette Scenarios (Focus Group) – what should the GP do, should he be concerned?

1. A young mother from an ethnic minority group who has got a history of depression and she's a single parent with two pre-school children. She goes to the doctor and she says she's not coping, she's having difficulty getting up in the morning and shopping and cooking, and she says she feels like killing herself, and that she's thought how she might do it. So when the GP suggests that he should refer her for some help, she says no, she doesn't want any help, that it would be wasting his time. Now what do you think the GP should do then?
2. This is a thirteen year old girl who goes to a GP, and she said that she's been having a sexual relationship with a family member for about two year and she thinks that she's pregnant, and she says that she only wants advice about having a termination and doesn't want any other help. How do you think the GP should respond?
3. This is a young mum who takes her eight year old daughter to the GP. The young mum's got some learning disabilities, and she's sort of quite well known to the community health

team and the health visitor. But the young mum says to the GP that she's worried that her daughter's been complaining of earache. Now the GP also notices that this little girl is very overweight and appears to have head lice as well, so she's got several problems. And when the GP looks in her ears he sees she's got an ear infection. Now do you think that the GP should contact anyone else about this young mum and her child?

4. This is a nineteen year old young mum who's got a history of alcohol and drug abuse. And she's got two children under five, and when she goes to the doctor he notices that she's got a lot of bruising on her arms and legs, and in passing she starts saying about her partner you know, disciplines the little boy because he's very naughty, and regularly gives him a good hiding. And then she says that her partner comes from a family which believes in discipline and that you know, she thinks it's right, he's such a naughty little boy that you know, he should be physically punished. What do you think a GP should do about something like that?

Other comments – own experiences of going to the GP and /or taking your children

Appendix 5: Delphi Panel areas of experience and expertise

(Panel members: A .. Y; *N* = 25)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
1.	X		X	X	X	X		X	X		X	X		X	X	X				X	X		X	X	X
2.			X							X						X				X					
3.							X	X												X					
4.	X						X							X	X				X	X	X			X	
5.						X						X					X						X		
6.		X	X				X	X	X													X			
7.	X		X															X	X			X	X		
8.				X				X		X					X		X		X	X			X		
9.																									
10.	X	X	X		X		X			X		X		X				X				X		X	X
11.	X	X					X			X						X		X		X	X	X	X	X	X
12.							X			X						X								X	X
13				X							X					X									
14.																				X				X	
15.				X													X								
16.	X		X									X						X				X	X	X	
17.											X									X				X	
18.					X																				
19.					X					X							X							X	
20.			X		X		X														X				
21.											X					X								X	
22.			X																						
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24.				X																					
25.							X																		
26.									X																
27.									X																
28.										X															
29.													X												
30.														X											
31.															X										
32.																X									

1. Parent/guardian
2. Child perspective
3. Service user
4. General practice
5. Social work
6. Nursing
7. Research
8. Education
9. Police
10. Child protection/safeguarding children practice
11. Child protection/safeguarding children policy
12. Domestic violence policy
13. Human rights
14. Ethnicity/diversity focus
15. Law
16. Mental health
17. Drug and alcohol
18. Physical disabilities
19. Learning disabilities
20. Paediatric practice
21. Asylum/immigration
22. Parental mental health
23. School governor
24. Ethics and professional guidelines development
25. Multi-agency working and partnership
26. Midwifery issues
27. Lecturer medical ethics
28. Co-ordinator of School Social Care Team
29. Experience in voluntary sector
30. GP tutor
31. Practice child protection lead
32. Acted for social workers on child death enquiries, advised fostering and adoption

Appendix 6: Delphi Study Vignettes

Vignette 1

Dr Clarke is a GP, working in a busy inner city practice, is coming towards the end of the morning clinic and the next patient is Comfort Kyamatuuku, a 34 year old woman, who has a history of depression. She is a single parent of two pre-school children and has brought them along to the surgery. Comfort tells the GP that she has difficulty getting up in the morning and with everyday activities such as shopping and cooking. She says she feels like killing herself and has thought about how she might go about this. She says she does not want to be admitted to hospital as 'I'd be wasting their time'.

How should Dr Clarke respond?

Vignette 2

Elaine O'Neill is a 19-year-old woman with a history of alcohol and drug abuse visits her GP, Dr Amoah, for an antenatal appointment. She has two children under 5. Dr Amoah notices extensive bruising on Elaine's forearms and legs. When asked about this, Elaine says 'Oh I keep walking into things', She mentions, in passing, that her new partner thinks that her two year old son (also Dr Amoah's patient) is deliberately 'very naughty' and regularly gives him a 'good hiding'. She says her partner comes from a culture that believes in 'discipline' and that she agrees that her son needs to be 'chastised'.

How should Dr Amoah respond?

Vignette 3

Joanne Perkins brings her eight year old daughter (Freya) to see the GP, Dr Imir. Joanne and her partner, Robert, have learning disabilities and are well-known to the community health team. Joanne tells Dr Imir that she has been very worried about her daughter as she has been complaining of pain in her ears. He observes that Freya is overweight and appears to have head lice. On investigation Dr Imir diagnoses an ear infection.

How should Dr Imir respond?

Vignette 4

Fiona Blythe-Smith is thirteen years old and has come to see her GP, Dr Johnstone. She says she fears that she is pregnant and discloses that she has been having a sexual relationship with a family member for two years. She says she wishes only to have advice about abortion and does not want any other intervention. Dr Johnstone has been the family doctor for twenty years.

How should Dr Johnstone respond?

Appendix 7: Delphi Study – Detailed overview of Delphi process

The ***Round 1 questionnaire*** included a set of four questions relating to the four vignettes and an additional eight questions relating specifically to conflicts of interests (APPENDIX *7i*). The first Delphi questionnaire was piloted with a small number of GPs and other health and social care professionals. Pilot responders were offered the opportunity to participate in subsequent rounds and 2 of these agreed to be members of the Delphi panel as part of the total of 25.

Figures 1, 2, 3 and 4 provide a more detailed overview of the Delphi Process.

Figure 1: Round 1 [*n* = 25/27]

The purpose of the first Delphi round was to obtain information, knowledge and opinion from the Panel of experts in relation to a range of questions relating to the research topic: conflicts of interests in general practice in relation to safeguarding children. Question areas are:

- Panel member's contact details and areas of experience and expertise;
- Panel members were asked to identify:
  The interests a GP should have in mind when safeguarding children?
  The different interests that might conflict in safeguarding of children?
  In what way might interests conflict?
  Whose interests a GP should give priority to when child abuse or neglect is suspected?
- In relation to each of four vignettes, Panel members were asked to respond to the following four questions (VQ):
  What issues arise?
  How should Dr X respond?
  Why should she respond in this way? and
  What might make a response difficult?
- Panel members were also asked to identify:
  The *sources of professional advice* a GP could draw on
  How a GP should respond in such cases
  The *principles* that should guide a GP when conflicts occur
  What they *understood* by '*conflicts of interest'* in the context of safeguarding children

The dataset was distilled to statements using a basic content analysis (Powell 2003) and subjected to team review. In order to reduce the questionnaire load on Delphi participants, the team decided to focus on GP *responses (VQ 2)* to the vignettes, *sources of professional advice*, *principles* and the Panel's *understanding* of 'conflicts of interests' in future rounds. The ***Round 2*** questionnaire (*APPENDIX 7ii*) was developed to feed back from round 1 while beginning to establish consensus on statements generated**.**

Building Consensus

It was agreed, following Powell (2003), that 'consensus was (to be) defined as 75% or more of participants agreeing/strongly agreeing' (p30). Consensus was established by a two-stage process: in the first stage, all statements in relation to a vignette or question (as above) were presented to the Panel members, who were asked to indicate their agreement/disagreement on a 4 point Likert scale (from strongly agree to strongly disagree). Panel members were also invited to provide additional comments. Any statement achieving at least 75% agreement at this stage was retained. In the second stage, Panel members were informed of the strength of agreement for all

statements, and statements achieving less than 75% agreement but greater than 25% were re-submitted to the Panel for further consideration, along with additional comments from the first stage, using the same Likert scale. Statements achieving less than 25% agreement were dropped. Those statements that continued to achieve under 75% were removed from consideration in the next round. A lack of response to a particular statement was treated as non-agreement.

Figure 2: Round 2 [*n* = 18/25]

The purpose of the second Delphi round was to ascertain *the degree* of consensus within the Panel in relation to the statements derived from the round one data.

- 64 statements were developed from the round 1 data in relation to *GP responses* to the 4 vignettes (n = 21, 14, 16 and 13). A further 47 statements of *principles that should guide a GP* and 30 statements relating to the Panel's *understanding of conflicts of interests* were developed from the round 1 data
- Panel members were invited to rate their agreement/disagreement with each item on a 4 point Likert scale. Comments were also invited.
- The Panel was invited to indicate the degree of *seriousness* and *urgency* applicable to each of the 4 vignettes on 6 point Likert scales.
- The Panel view of the *importance* of 39 *sources of professional advice* identified in round 1 was invited on a 6 point scale

Mean scores for agreement were calculated. Additional comments and suggestions were analysed and new statements derived from Round 2 comments were selected for the next round where they were considered significantly different from existing statements. In the ***Round 3*** questionnaire (APPENDIX7*iii*) the Panel reconsidered responses that had not achieved consensus and was asked to *prioritise* these on a Likert scale from 1 (low) to 6 (high).

Figure 3: Round 3 [*n* = 14/25]

The purpose of the round 3 questionnaire was to ascertain the Panel's view of:

- *Vignette statements* from the round 2 data relating to GP responses to the 4 vignettes: their *priority* of statements from *the 4 vignettes* (n = 19, 11, 11 and 8) on a 6 point Likert scale; the opportunity to reconsider items achieving greater than 25% but less than 75% agreement (n = 2, 3, 5 and 4); and their level of agreement in relation to new items from the 4 vignettes in Round 2 (n = 6, 9, 6 and 3).

The Panel was asked

- *principle* statements achieving greater than 25% but less than 75% agreement (8) and new statements (3); and also to to review their agreement/disagreement to;
- *understanding conflict* statements, achieving greater than 25% but less than 75% agreement (18) and new statements (1)

Feedback was given from Round 2 on:

- *vignette statements* removed due to less than 25% agreement (n = 0, 0, 0 and 1);
- *principle* statements achieving 75% or more agreement (38);
- *understanding conflicts statements* achieving 75% or more agreement (12) and those removed due to less than 25% agreement (1);
  (contd.)
- the *urgency and seriousness rating* of the 4 vignettes; and
- the *sources of professional advice* ratings (29, and 10 more relating to specific vignettes).

In the ***Round 4*** questionnaire (APPENDIX 7 iv) Panel members were asked to identify the appropriate *timing* for each *response* to each vignette. Feedback was given from the Round 3 Questionnaire and Panel members had the opportunity to consider *priority* of statements previously retained, to reconsider statements of *principles* and to identify 3 statements that best described *conflicts of interests*.

Figure 4: Round 4 [n = 14/25]

The purpose of the round 4 questionnaire is to ascertain the Panel view regarding

- the appropriate timing for each *GP response* statement in relation to each *vignette*. Options were: By the end of the consultation (1); By the end of that day's surgery (2); By the end of the following day (3); Over a longer period (4); or Response time doesn't apply (5)
- their *priority (*on a 6 point Likert scale) and *response times (as above)* for Round 3 *vignette statements* now achieving 75% or more agreement from the 4 vignettes (n = 4, 7, 4 and 3)

The Panel were also asked to indicate:

- the *importance* they attached to each of the *principle* statements (42) on a scale of 1 (unimportant) to (10 highly important) and
- their 3 most favoured statements (of 13) relating to the Panel's *understanding of conflicts of interest.*

Feedback was given from Round 3 on:

- *vignette statements* agreement ratings and prioritization and statements removed due to less than 75% agreement (n = 4, 5, 7 and 4),
- the rating*s of principle* statements achieving 75% or more agreement (42) and those removed due to less than 75% agreement (9); and
- the rating*s of understanding conflicts statements* achieving 75% or more agreement (13) and those removed due to less than 75% agreement (17).

Appendix 7i: Delphi questionnaire - Round 1

Protocol and Notes for Participants

About the 'Conflicts of Interest for GPs in Safeguarding Children' Project

This Delphi consultation is part of a research project designed to explore the possible conflicts of interests raised in relation to safeguarding children when a General Practitioner (GP) has both a child and an alleged perpetrator as patients. The project aims to suggest ways of responding to and, where possible, resolving conflicts of interests.

The project is funded by the Department for Education and Skills and the Department of Health and the research team is based in the School of Social Work in the Faculty of Health and Social Care Sciences in Kingston University and St George's University of London.

1 . About the Delphi Expert Consultation

The Delphi technique gets its name from a Greek shrine dating back to 1400 BC. The Oracle refers to a person or authority alleged to predict the future and give wise counsel. The technique has been used since the 1950s as a means to obtain a consensus of expert opinion in relation to complex issues or problems. In addition to its use as a forecasting procedure it has been used for many other purposes, for example, evaluation, planning and formulating good practice.

This Delphi consultation has three or four rounds or phases. This first round is an initial exploration of your expert views relating to the role and conflicts of interests arising from GP involvement in child protection. All responses will be collated and analysed and feedback given to everyone in the expert panel. The second round questionnaire will be amended based on findings from the first round and area of agreement and disagreement presented. The final phase occurs when all previously gathered information has been analysed, evaluations fed back and consensus reached.

2 . About your contribution

This is an opportunity for you to share your expert opinion regarding an important aspect of child protection. It will involve you sharing your expertise with us by completing three or four questionnaires over a three or four month period. A questionnaire will be sent to you by email (unless you have requested a paper copy) at the beginning of each month and you will have two weeks to complete and return it.

The questionnaires invite you to share your views based on your knowledge and experience in practice, policy-making, education and/or research. Please answer the questions as fully and frankly as possible.

3 . How results will be managed and disseminated

A final report of the Delphi findings will be produced and this will be incorporated into the overall research project report. The reports will form the basis of publications that will appear in professional and peer-reviewed journals. A practice guide will also be developed for GPs when dealing with child protection issues and conflicts of interest. This will be made available initially at a training workshop. You will receive copies of the report and the practice guide on completion of the project.

4 . Ethical considerations

This project has been approved by South East Multi-Centre Research Ethics Committee and by the relevant Research and Development committee in each of the participating Primary Care Trusts.

Confidentiality will be maintained and your contributions will be anonymised. No identifiable information will be included in the Delphi rounds or in project publications.

5 . Further information

If you have any questions about the Delphi questionnaire or any other aspects of the project
please contact:

Ms Rozalind Neatby,
Research Programmes Administrator,
School of Social Work,
Kingston University,
Kingston Hill KT2 7LB Phone: 0208 547 8669

Contact Details & Areas of Expertise

Your individual responses to the Delphi expert consultation will be confidential and used anonymously. However, we need you to put your name and contact details on your completed questionnaire so that we can contact you again to feed back on the results in subsequent rounds of the Delphi.

Please note: All information circulated will be anonymised.

Name:
Areas of experience and expertise:

Please indicate all areas of your expertise

Parent/guardian	[ ]	Child protection policy	[ ]
Child perspective	[ ]	Domestic violence policy	[ ]
Service user	[ ]	Human rights	[ ]
General practice	[ ]	Ethnicity/diversity focus	[ ]
Social work	[ ]	Law	[ ]
Nursing	[ ]	Mental health	[ ]
Research	[ ]	Drug and alcohol	[ ]
Education	[ ]	Physical disabilities	[ ]
Police	[ ]	Learning disabilities	[ ]
Child protection practice	[ ]	Paediatric practice	[ ]
		Asylum/immigration	[ ]

Other relevant areas of experience and expertise……

Conflicts of Interests for General Practitioners in Safeguarding Children

Please type within the boxes. These will expand to take any amount of text. In hard copy you may continue your answers on additional pages using as many as you like.

1. Whose interests should a General Practitioner (GP) have in mind when safeguarding children? Please list as many as you can.
2. Which of these interests might conflict with each other in the safeguarding of children?
3. In what way might these interests conflict in the safeguarding of children? Please give examples.
4. Whose interests should a GP give priority to when child abuse or neglect is suspected?

5. Consider the following examples and please respond to the questions in the box.

A. Dr Clarke is a GP, working in a busy inner city practice, is coming towards the end of the morning clinic and the next patient is Comfort Kyamatuuku, a 34 year old woman, who has a history of depression. She is a single parent of two pre-school children and has brought them along to the surgery. Comfort tells the GP that she has difficulty getting up in the morning and with everyday activities such as shopping and cooking. She says she feels like killing herself and has thought about how she might go about this. She says she does not want to be admitted to hospital as 'I'd be wasting their time'.

What issues arise?
How should Dr Clarke respond?
Why should she respond in this way?
What might make a response difficult?

B. Elaine O'Neill is a 19 year old woman with a history of alcohol and drug abuse visits her GP, Dr Amoah, for an antenatal appointment. She has two children under 5. Dr Amoah notices extensive bruising on Elaine's forearms and legs. When asked about this, Elaine says 'Oh I keep walking into things', She mentions, in passing, that her new partner thinks that her two year old son (also Dr Amoah's patient) is deliberately 'very naughty' and regularly gives him a 'good hiding'. She says her partner comes from a culture that believes in 'discipline' and that she agrees that her son needs to be 'chastised'.

What issues arise?
How should Dr Amoah respond?
Why should he respond in this way?
What might make a response difficult?

C. Joanne Perkins brings her eight year old daughter (Freya) to see the GP, Dr Imir. Joanne and her partner, Robert, have learning disabilities and are well-known to the community health team. Joanne tells Dr Imir that she has been very worried about her daughter as she has been complaining of pain in her ears. He observes that Freya is overweight and appears to have head lice. On investigation Dr Imir diagnoses an ear infection.

What issues arise?
How should Dr Imir respond?
Why should she respond in this way?
What might make a response difficult?

D. Fiona Blythe-Smith is thirteen years old and has come to see her GP, Dr Johnstone. She says she fears that she is pregnant and discloses that she has been having a sexual relationship with a family member for two years. She says she wishes only to have advice about abortion and does not want any other intervention. Dr Johnstone has been the family doctor for twenty years.

What issues arise?
How should Dr Johnstone respond?
Why should he respond in this way?
What might make a response difficult?

6. What resources can a GP draw on when conflicts of interests arise and from whom can he/she seek advice?
7. How should GPs respond to, or resolve, conflicts of interest? What actions should he/she take?
8. What principles should guide a GP when conflicts of interests occur in the safeguarding of children?
9. Please say, in your own words, what you understand by ‘conflicts of interest’ in the context of safeguarding children?

Thank you for your responses and for sharing your expertise and experience with us.

We will collate the responses and will be inviting you to complete the second round

Appendix 7ii: Delphi Questionnaire – Round 2

Dear Panel Member,

Thank you very much for completing the Round 1 Questionnaire. We now invite you to complete the Round 2 Questionnaire.

In feeding back the wide range of expertise and experience shared in Round 1 we have reduced the material to statements. In some cases we have paraphrased several similar responses to make one statement. In other cases we have used the actual words of a respondent. We have focused on material relating to the vignettes, principles and on your understanding of conflicts of interest.

Responses are invited in the form of scales on which you are asked to state the level of agreement you think appropriate by putting an X in the relevant box in relation to each statement, for example:

Strongly Agree	Agree	Disagree	Strongly Disagree
	X		

The statements are not presented in any particular order although some statements relating to similar issues have been grouped together. You are also asked to rate the degree of urgency and seriousness that applies to each vignette. There is space for you to add comments, other statements or different perspectives if the options presented do not capture your perspective on the issue. There is also a Table listing possible sources of professional advice, which was collated from Question 6 of the Round One questionnaire and from vignette responses.
Findings from the Delphi process will contribute to the development of a final project report and a practice guide that will also be developed for General Practitioners. You will receive copies of the report and the practice guide on completion of the project.

Again, we invite you to respond as fully and frankly as possible. All of the contributions have been anonymised. The final phase of the Delphi process will occur when all previously gathered information has been analysed, evaluations fed back and consensus reached.

If you have any questions about the Delphi questionnaire or any other aspects of the project please contact: Ms Rozalind Neatby, Research Programmes Administrator, School of Social Work, Kingston University, Kingston Hill KT2 7LB. Phone: 0208 547 8669

Yours sincerely,

The Project Team

VIGNETTE 1

Dr Clarke is a GP, working in a busy inner city practice, is coming towards the end of the morning clinic and the next patient is Comfort Kyamatuuku, a 34 year old woman, who has a history of depression. She is a single parent of two pre-school children and has brought them along to the surgery. Comfort tells the GP that she has difficulty getting up in the morning and with everyday activities such as shopping and cooking. She says she feels like killing herself and has thought about how she might go about this. She says she does not want to be admitted to hospital as 'I'd be wasting their time'.

First, please indicate the degree of seriousness and urgency you think applies to this vignette:

	1	***2***	***3***	***4***	***5***	***6***	
Serious							Not Serious

	1	***2***	***3***	***4***	***5***	***6***	
Urgent							Not Urgent

In relation to Vignette 1, how should Dr Clarke respond?

	Strongly agree	**Agree**	**Disagree**	**Strongly disagree**
1. Dr Clarke should assess the nature and severity of Comfort's mental health problems				
2. Dr Clarke should assess risks to Comfort, for example, in relation to self-harm and suicide				
3. Dr Clarke should consider whether or not Comfort needs to be detained under a section of the Mental Health Act				
4. Dr Clarke should assess Comfort's mental capacity				
5. Dr Clarke should identify appropriate interventions in response to Comfort's mental health problems				
6. Dr Clarke should respond appropriately to Comfort's cultural needs by, for example, making a referral to a cross-cultural psychiatrist				

7. If Comfort's first language is not English, Dr Clarke should arrange another appointment and involve an interpreter				
8. Dr Clarke should assess the well-being of Comfort's children				
9. Dr Clarke should assess risks to the children arising from Comfort's mental health problems				
10. Dr Clarke should obtain information about family and social support for Comfort and her children				
11. Dr Clarke should make time to establish a rapport with Comfort and listen to her carefully				
12. Dr Clarke should gain a broader picture and understanding of how Comfort is feeling and responding				
13. Dr Clarke should seek Comfort's permission to discuss her situation with other professionals				
14. Dr Clarke should ask the Health Visitor to assess the home situation				
15. Dr Clarke should discuss his concerns with Comfort and explain that he needs to make a referral to Social Services				
16. Dr Clarke should refer Comfort and her children to Social Services				
17. Dr Clarke should inform Comfort of the limits of confidentiality, that is, what information may be shared with whom, why and what might follow from this				
18. Dr Clarke should use professional judgement and not jump to conclusions				
19. Dr Clarke should 'seize the moment'. This opportunity to help the family may not arise again				
20. Dr Clarke should listen carefully and judge slowly				
21. Dr Clarke should complete contemporaneous, timed and dated notes clearly detailing his concerns and the action he will take				

Please add comments or suggestions for amendments, if any, here (these boxes will expand as you type):

VIGNETTE 2

Elaine O'Neill is a 19 year old woman with a history of alcohol and drug abuse visits her GP, Dr Amoah, for an antenatal appointment.She has two children under 5. Dr Amoah notices extensive bruising on Elaine's forearms and legs. When asked about this, Elaine says 'Oh I keep walking into things', She mentions, in passing, that her new partner thinks that her two year old son (also Dr Amoah's patient) is deliberately 'very naughty' and regularly gives him a 'good hiding'. She says her partner comes from a culture that believes in 'discipline' and that she agrees that her son needs to be 'chastised'.

First, please indicate the degree of seriousness and urgency you think applies to this vignette:

	1	***2***	***3***	***4***	***5***	***6***	
Serious							Not Serious

	1	***2***	***3***	***4***	***5***	***6***	
Urgent							Not Urgent

In relation to Vignette 2, how should Dr Amoah respond? Please add any comments or suggestions for amendments, if any, here:

	Strongly agree	**Agree**	**Disagree**	**Strongly disagree**
1. Dr Amoah should assess the severity and impact of Elaine's drug problems on her pregnancy and ability to care for her children				
2. Dr Amoah should discuss treatment options, regarding her drug and alcohol problems, with Elaine				
3. Dr Amoah should investigate the causes of bruising on Elaine's forearms and legs				
4. Dr Amoah should provide information and advice regarding domestic violence, for example, information about Women's Aid refuges and an exit plan				
5. Dr Amoah should ask questions about 'chastisement' of the 2 year old child and consider the possibility of physical abuse				
6. Dr Amoah should make time to establish a rapport with Elaine and listen to her carefully				

7. Dr Amoah should seek additional information from the Health Visitor				
8. Dr Amoah should ask Elaine to bring her two children to the surgery later that day or the next				
9. Dr Amoah should discuss his concerns with Elaine and explain that he needs to make a referral to Social Services				
10. Dr Amoah should refer to Social Services as a matter of urgency				
11. Dr Amoah should discuss childcare options, for example, nursery places if no childcare is currently being accessed				
12. Dr Amoah should consider the consequences of disclosing information, for example, increased violence				
13. Dr Amoah should listen carefully and judge slowly				
14. Dr Amoah should document his concerns fully, clearly and contemporaneously including an action plan				

VIGNETTE 3

Joanne Perkins brings her eight year old daughter (Freya) to see the GP, Dr Imir. Joanne and her partner, Robert, have learning disabilities and are well-known to the community health team. Joanne tells Dr Imir that she has been very worried about her daughter as she has been complaining of pain in her ears. He observes that Freya is overweight and appears to have head lice. On investigation Dr Imir diagnoses an ear infection.

First, please indicate the degree of seriousness and urgency you think applies to this vignette:

	1	***2***	***3***	***4***	***5***	***6***	
Serious							Not Serious

	1	***2***	***3***	***4***	***5***	***6***	
Urgent							Not Urgent

In relation to Vignette 3, how should Dr Imir respond?

	Strongly agree	Agree	Disagree	Strongly disagree
1. Dr Imir should assess Joanne's parenting capabilities				
2. Dr Imir should assess Joanne's mental health				
3. Dr Imir should assess Freya's general health and needs				
4. Dr Imir should include Freya in explanations and discussion				
5. Dr Imir should adopt a sensitive and non-judgemental approach				
6. Dr Imir should view the problems presented as normal problems in children rather than inadequate or poor parenting				
7. Dr Imir should explain the need to liaise with teacher and school nurse to investigate Freya's situation further				
8. Dr Imir should ask whether the parents would welcome more support				
9. Dr Imir should offer health information regarding diet and the detection of head lice				

10. Dr Imir should offer treatment for Freya's ear infection				
11. Dr Imir should seek the assistance of a patient advocate depending on the severity of Joanne's learning disability				
12. Dr Imir should not be complacent just because family are 'well-known' to the team				
13. Dr Imir should consider the appropriateness and accessibility of practice resources in relation to disability				
14. Dr Imir should seek permission to involve the wider family in care provision				
15. Dr Imir should listen carefully and judge slowly				
16. Dr Imir should consult with the Community Health Team with a view to the team completing a Common Assessment Framework (CAF) and then calling a Team Around the Child (TAC)				

Please add comments or suggestions for amendments, if any, here:

VIGNETTE 4

Fiona Blythe-Smith is thirteen years old and has come to see her GP, Dr Johnstone. She says she fears that she is pregnant and discloses that she has been having a sexual relationship with a family member for two years. She says she wishes only to have advice about abortion and does not want any other intervention. Dr Johnstone has been the family doctor for twenty years.

First, please indicate the degree of seriousness and urgency you think applies to this vignette:

	1	***2***	***3***	***4***	***5***	***6***	
Serious							Not Serious

	1	***2***	***3***	***4***	***5***	***6***	
Urgent							Not Urgent

In relation to Vignette 3, how should Dr Johnstone respond?

	Strongly agree	**Agree**	**Disagree**	**Strongly disagree**
1. Dr Johnstone should give Fiona a pregnancy test				
2. Dr Johnstone should assess Fiona's mental capacity				
3. Dr Johnstone should obtain information about the 'sexual relationship' without interrogating her or asking leading questions				
4. Dr Johnstone's approach should be open and non-judgemental				
5. Dr Johnstone should offer counseling to Fiona				
6. Dr Johnstone should place limits on his duty to maintain confidentiality and explain to Fiona why and what he might need to disclose				
7. Dr Johnstone should encourage Fiona to confide in someone she trusts in the family				
8. Dr Johnstone should make an immediate referral to Social Services				
9. Dr Johnstone should contact the police				
10. Dr Johnstone should have a female				

chaperone during the consultation				
11. Dr Johnstone should refer Fiona to a female General Practitioner				
12. Dr Johnstone should help prepare the GP Practice for the fallout that may follow, for example, requests, demands and complaints from other family members (seek medicolegal advice and have another colleague respond to family requests)				
13. Dr Johnstone should listen carefully and judge slowly				

In relation to Vignette 4, how should Dr Johnstone respond? Please add comments or suggestions for amendments, if any, here:

To whom or where should GPs go to for professional advice ….

(Please rank from 1 (unimportant) to 6 (highly important) by putting an **X** in the appropriate box)

A: In relation to conflicts of interests and safeguarding issues generally:	1	2	3	4	5	6
1. General Medical Council						
2. Medical Defence Union						
3. Experienced colleagues in the practice						
4. Named/designated professionals for safeguarding children						
5. British Medical Association						
6. Local paediatric experts/team						
7. Health visitor						
8. Department of Health guidelines						
9. School nurse						
10. Police						
11. Council services e.g. schools and nurseries						
12. Resources within the practice: mental health practitioners, nurses, OTs, other GP's etc						
13. Primary community mental health teams						
14. Older adult services						
15. Community child and adolescent mental health teams						

16. Drug and alcohol community teams						
17. Community paediatric teams						
18. Charities and support groups e.g. ethnic minority support groups						
19. Citizens advisory service						
20. Crisis advisory service						
21. The advice of Senior Partner						
22. GP procedures manual						
23. GP training information						
24. Legal frameworks e.g. Children's Act						
25. LCSB local guidelines						
26. RCGPs' statements of principles						
27. Practice counsellor						
28. Children services specialists						
29. Social Services						

B: in relation to specific vignettes.	1	2	3	4	5	6
• Mental health services (Vignette 1 – Comfort)						
• Trans-cultural psychiatrist (Vignette 1)						
• Midwife (Vignette 2 – Elaine)						
• Domestic abuse helpline (Vignette 2)						
• Family key workers (Vignette 3 – Joanne)						
• Community health team (Vignette 3)						
• Dietician (Vignette 3)						
• Forensic medical examiner (Vignette 4 – Fiona						
• Counselling services (Vignette 4)						
• Medico-legal services (Vignette 4)						

Please add comments or suggestions for amendments, if any, here:

The following statements, derived from the Round 1 questionnaire, summarise principles that should guide a GP when conflicts of interests occur in the safeguarding of children.

Please indicate your level of agreement in relation to each statement**.**

	Strongly agree	Agree	Disagree	Strongly disagree
1. The child's interests must be foremost – at all times all actions must be in the interest of the needs and safety of the child				
2. A balance must always be considered between the interests of the child and the implications for the family				
3. GPs must trust colleagues who have expertise and not try to go it alone. Services are multi-professional for a reason				
4. GPs should train with other professionals and get in on the local networks				
5. Communication is most important: if a GP ever feels unhappy with a decision that has been made, he or she should discuss it with parties involved				
6. GPs should used the named professional lead as the lynch pin, as he or she should be aware of all decisions made				
7. GPs should determine what the child's best interest is				
8. GPs should determine how the affected parties feel although this may be difficult				
9. Patients of all ages are owed a duty of confidentiality				
10. The medical principle of patient confidentiality, including that owed to the child itself, may need to be overridden in order to safeguard the child				
11. GPs should be sensitive to the effect of breaking confidentiality on an individual and make each individual aware of whom information has been shared with				
12. Conflict may be more apparent than real				
13. Conflict may be greater for the GP than for family members				

14. Seek consent where possible but if this is not possible, or consent is withheld, ensure that only issues related to the protection of the child are disclosed				
15. Respect different cultures and understand their belief systems				
16. GPs must adhere to the legal framework, especially the Human Rights Act, the Convention on the Rights of the Child, and advice from the GMC on the Duties of a Doctor as all provide important principles				
17. A GP has a statutory duty to take action when necessary to protect a child				
18. Local procedures, professional guidance and law make it clear that the GP is under a duty to safeguard children and share information with appropriate agencies				
19. To do nothing if child abuse is suspected is not an option				
20. Decisions must be based on evidence and analysis of the information gathered rather than assumptions				
21. GPs should adopt a holistic approach when making the assessment including practical, medical, psychological, social, cultural, moral and legal dimensions				
22. A GP must be honest at all times when dealing with these issues				
23. GPs must make a professional judgement as to the level of safety/health of a child				
24. A GPs professional judgement as to the level of safety/health of a child overrides any social circumstances that may arise from breaking confidentiality				
25. GPs have a duty to support vulnerable parents in their efforts to protect and nurture their children				
26. GPs must take into account the autonomous wishes of the individual and other peoples' needs/desires in outcome of problem				
27. Always record, date and time all interactions with client, what concerns are, why and the course of action taken				
28. GPs should be aware that all parties have interests and rights				

29. Seeing children as part of the family context, and helping and supporting parents may be the best way of safeguarding children				
30. Seeing children as separate entities from the family, while sometimes essential, is not always so, and can do serious, long term damage				
31. GPs should follow the principles set out in the Local Safeguarding Procedures				
32. The number one principle is the safety of the child				
33. GPs should always follow local sharing information protocols				
34. GPs should use the therapeutic relationship as much as possible to help resolve issues				
35. GPs should always be transparent and uphold professional values				
36. The cardinal principle is that the welfare of the child is paramount				
37. Where conflicts with the interests of adults arise, the welfare of the child is the over-riding consideration				
38. The GP should be prepared to admit mistakes				
39. If other agencies are mistaken, GPs should defend the interests of their patients				
40. GP should declare competing interests if appropriate				
41. GP should learn from difficult experiences relating to conflicts of interest				
42. GP should engage in a Significant Event Analysis				
43. GP should bring conflicting parties together and facilitate negotiation				
44. GP should aim to do no harm, seeking the most therapeutic outcome				
45. GP should have child protection training and keep updated				
46. GP should aim to make all members of the family feel respected				
47. GP should attempt to retain the trust of non-abusing relatives				

The following statements, derived from the Round 1 questionnaire, summarise the panel's understanding of 'conflicts of interests' in the context of safeguarding children. Please indicate your level of agreement in relation to each statement.

	Strongly agree	Agree	Disagree	Strongly disagree
1. Where there is a conflict between the care of a patient and the interests of a child				
2. Where the needs of a child are at odds with those of the parents or others				
3. Where there is a feeling of divided loyalties				
4. Where a child does not want parental involvement				
5. Where a GP is concerned about children but an adult does not want others involved				
6. Where a GP is concerned about children but worried that if concern is expressed the adult will not seek help				
7. Where GP experiences a dilemma because of lack of confidence in social services and the police				
8. Where a GP fears that intervention may cause more harm than good				
9. Where the interests of an individual patient conflict with interests of other patients				
10. Where the interests of an individual patient conflict with interests of society				
11. Where the interests of an individual patient conflict with professional values				
12. Where there is a conflict of values, for example, confidentiality and child welfare				
13. Where professional actions may result in a breach of trust				
14. Where there is a conflict between the duty to obtain parental consent and also to safeguard children				
15. Where someone in a position of trust has competing personal or professional interests making it difficult to fulfill duties impartially				
16. Where the needs of family members do not concur				
17. Where proposed action of the GP is not supported by others				
18. Where there is a conflict between self-interest and the interests of others				

19. Where the welfare, safety and interests of a child are to be decided against a background of patient confidentiality				
20. Where each individual has an interest but where protecting the interests of one individual might put the other at risk				
21. Arises when doing what is good for one person causes harm to another				
22. Where the effect of a decision has a potentially negative consequence that may counterbalance the positive effect and where there is no clear answer as to the best course of action				
23. Where there is a need to protect and safeguard the interests of both the adult and the child				
24. Where reasoning about interests result in agonies of indecision as to where duties lie				
25. Where putting the child's interests first, causing harm to someone may unintentionally, cause harm to the child				
26. Where different interests of an individual child conflict, for example, wishing abuse to stop but wanting father to remain at home				
27. Where different interests of a non-abusing parent may conflict, for example, mother who wishes abuse to stop but needs partner's income				
28. Where different interests of the GP may conflict, for example, safeguarding children work and meeting national targets				
29. Where a child's right to be safe conflicts with the lobby for disabled parents rights				
30. Where an individual is trying to balance both the long and short term view realizing there may be hidden issues about which he/she has no knowledge				
31. I find the concept of 'safeguarding' so hazy that this question is impossible to answer				

Please add comments or suggestions for amendments, if any, here:

Thank you very much for completing the Round 2 questionnaire

Appendix 7iii: Delphi questionnaire – Round 3

Dear Panel Member,

Thank you very much for completing the Round 1 and 2 Questionnaires. We now invite you to complete the Round 3 Questionnaire. We have collated the Panel's responses in relation to the statements in the Round 2 questionnaire. Statements relating to the vignettes that achieved 75% agreement or greater have been retained and we now ask you to ***prioritise*** these statements. Statements with less than 25% agreement in Round 2 have been removed. Where there was less than 75% but greater than 24% agreement we now invite you to reconsider your agreement with the statements. We have taken note of comments or suggestions and, where appropriate, have added new statements.

Responses are again invited in the form of scales on which you are asked to state the level of agreement or importance you think appropriate by putting an X in the relevant box in relation to each statement as in Round 2. Where agreement has been reached we show the level of agreement from Round 2 and ask you to assess importance:

		Prioritisation					
		Low					High
	Agreement from Round 2	1	2	3	4	5	6
1. Dr Clarke should assess the nature and severity of Comfort's mental health problems	100%			**X**			

The statements are presented in order with those achieving higher scores presented first. There is space for you to add comments, other statements or different perspectives if the options presented do not capture your perspective on the issue.

For the sections on principles and understanding relating to conflicts of interests, in this Round we ask you to consider statements that received less than 75% agreement along with new statements from Round 2. You will have an opportunity to consider the full range of statements achieving consensus in the 4th and final Round.

At the end of the document we have included findings from Round 2 relating to the urgency and seriousness rating of the 4 vignettes (Appendix A) and from the Round 2 resources question (Appendix b) so you can see how these resources were rated.

Again, we invite you to respond as fully and frankly as possible. All of the contributions have been anonymised. The final phase of the Delphi process will occur when all previously gathered information has been analysed, evaluations fed back and consensus reached. If you have any questions about the Delphi questionnaire or any other aspects of the project please contact: Ms Rozalind Neatby, Research Programmes Administrator, School of Social Work, Kingston University, Kingston Hill KT2 7LB. Phone: 0208 547 8669

Yours sincerely,

The Project Team

VIGNETTE 1

Dr Clarke is a GP, working in a busy inner city practice, is coming towards the end of the morning clinic and the next patient is Comfort Kyamatuuku, a 34 year old woman, who has a history of depression. She is a single parent of two pre-school children and has brought them along to the surgery. Comfort tells the GP that she has difficulty getting up in the morning and with everyday activities such as shopping and cooking. She says she feels like killing herself and has thought about how she might go about this. She says she does not want to be admitted to hospital as 'I'd be wasting their time'.

How should Dr Clarke respond?
Please rate each statement in order of *priority* from 1 (low priority) to 6 (high priority).
The percentage of agreement from Round 2 is indicated in the second column.

		Prioritisation Low → High					
	Agreement from Round 2	1	2	3	4	5	6
1. Dr Clarke should assess the nature and severity of Comfort's mental health problems	100%						
2. Dr Clarke should assess risks to Comfort, for example, in relation to self-harm and suicide	100%						
3. Dr Clarke should identify appropriate interventions in response to Comfort's mental health problems	100%						
4. Dr Clarke should assess risks to the children arising from Comfort's mental health problems	100%						
5. Dr Clarke should obtain information about family and social support for Comfort and her children	100%						
6. Dr Clarke should make time to establish a rapport with Comfort and listen to her carefully	100%						
7. Dr Clarke should use professional judgement and not jump to conclusions	100%						
8. Dr Clarke should complete contemporaneous, timed and dated notes clearly detailing his concerns and the action he will take	100%						
9. Dr Clarke should assess Comfort's mental capacity	94%						
10. Dr Clarke should assess the well-being of Comfort's children	94%						
11. Dr Clarke should seek Comfort's permission to discuss her situation with other professionals	94%						
12. Dr Clarke should ask the Health Visitor to assess the home situation	94%						

13. Dr Clarke should inform Comfort of the limits of confidentiality, that is, what information may be shared with whom, why and what might follow from this	94%						
14. Dr Clarke should gain a broader picture and understanding of how Comfort is feeling and responding	89%						
15. Dr Clarke should 'seize the moment'. This opportunity to help the family may not arise again	89%						
16. Dr Clarke should listen carefully and judge slowly	89%						
17. Dr Clarke should consider whether or not Comfort needs to be detained under a section of the Mental Health Act	83%						
18. Dr Clarke should discuss his concerns with Comfort and explain that he needs to make a referral to Social Services	78%						
19. Dr Clarke should refer Comfort and her children to Social Services	78%						

This section lists statements that received less than 75% support in Round 2 or were added as comments/suggestions.

In light of the responses from others and the additional suggestions please could you now indicate your level of agreement:

	Agreement from Round 2	Strongly agree	Agree	Disagree	Strongly disagree
1. Dr Clarke should respond appropriately to Comfort's cultural needs by, for example, making a referral to a cross-cultural psychiatrist	67%				
2. If Comfort's first language is not English, Dr Clarke should arrange another appointment and involve an interpreter	56%				
3. In responding to Comfort's cultural needs Dr Clarke should not make assumptions and offer Comfort choice	Suggestion from Round 2				
4. Dr Clarke should try to carry out some form of assessment, possibly using online translation tools	Comment from Round 2				
5. Dr Clarke should involve the Health Visitor on an on-going basis not merely on a one-off home assessment	Comment from Round 2				

6. Dr Clarke should have an informal discussion with a senior social worker to talk around the problem rather than a straightforward referral	Comment from Round 2				
7. Dr Clarke should decide if the referral is for a child in need or a child in need of protection from significant harm	Comment from Round 2				
8. The responses to some statements depend on those from others – each cannot be addressed in isolation	Comment from Round 2				

Comments/suggestions relating to Vignette 1 statements:

VIGNETTE 2

Elaine O'Neill is a 19 year old woman with a history of alcohol and drug abuse visits her GP, Dr Amoah, for an antenatal appointment. She has two children under 5. Dr Amoah notices extensive bruising on Elaine's forearms and legs. When asked about this, Elaine says 'Oh I keep walking into things', She mentions, in passing, that her new partner thinks that her two year old son (also Dr Amoah's patient) is deliberately 'very naughty' and regularly gives him a 'good hiding'. She says her partner comes from a culture that believes in 'discipline' and that she agrees that her son needs to be 'chastised'.

How should Dr Amoah respond?
Please rate each statement in order of *priority* from 1 (low priority) to 6 (high priority). The percentage of agreement from Round 2 is indicated in the second column.

		Prioritisation Low → High					
	Agreement from Round 2	1	2	3	4	5	6
1. Dr Amoah should assess the severity and impact of Elaine's drug problems on her pregnancy and ability to care for her children	100%						
2. Dr Amoah should ask questions about 'chastisement' of the 2 year old child and consider the possibility of physical abuse	100%						
3. Dr Amoah should consider the consequences of disclosing information, for example, increased violence	100%						
4. Dr Amoah should investigate the causes of bruising on Elaine's forearms and legs	94%						
5. Dr Amoah should make time to establish a rapport with Elaine and listen to her carefully	94%						
6. Dr Amoah should seek additional information from the Health Visitor	94%						
7. Dr Amoah should listen carefully and judge slowly	94%						
8. Dr Amoah should document his concerns fully, clearly and contemporaneously including an action plan	94%						
9. Dr Amoah should provide information and advice regarding domestic violence, for example, information about Women's Aid refuges and an exit plan	89%						

10. Dr Amoah should discuss his concerns with Elaine and explain that he needs to make a referral to Social Services	89%						
11. Dr Amoah should discuss treatment options, regarding her drug and alcohol problems, with Elaine	83%						

This section lists statements that received less than 75% support in Round 2 or were added as comments/suggestions.

In light of the responses from others and the additional suggestions please could you now indicate your level of agreement:

	Agreement from Round 2	Strongly agree	Agree	Disagree	Strongly disagree
1. Dr Amoah should refer to Social Services as a matter of urgency	72%				
2. Dr Amoah should ask Elaine to bring her two children to the surgery later that day or the next	61%				
3. Dr Amoah should discuss childcare options, for example, nursery places if no childcare is currently being accessed	50%				
4. Dr Amoah should speak to Children's Social Care whilst the mother is still at the surgery so that a safe means of intervention can be agreed	Comment from Round 2				
5. Dr. Amoah needs to manage this situation within an interagency framework	Comment from Round 2				
6. Dr Amoah needs to discuss this situation with the midwife	Comment from Round 2				
7. Dr Amoah must be very clear about agreed outcomes should he have an informal discussion with social worker	Comment from Round 2				
8. Dr Amoah should be aware that asking questions about 'chastisement' is a potentially risky strategy and Elaine may walk out if challenged	Comment from Round 2				
9. Dr Amoah draft an action plan in conjunction with other professionals	Comment from Round 2				
10. Dr Amoah should see the children immediately, not later on or the next day	Comment from Round 2				

11. Dr Amoah should ask the Health Visitor to visit the family urgently to assess the children and the home environment	Comment from Round 2				
12. Discussing childcare options is not the GP's role – refer if necessary to Health Visitor or Social Worker	Comment from Round 2				

Comments/suggestions relating to Vignette 2 statements:

VIGNETTE 3

Joanne Perkins brings her eight year old daughter (Freya) to see the GP, Dr Imir. Joanne and her partner, Robert, have learning disabilities and are well-known to the community health team. Joanne tells Dr Imir that she has been very worried about her daughter as she has been complaining of pain in her ears. He observes that Freya is overweight and appears to have head lice. On investigation Dr Imir diagnoses an ear infection.

How should Dr Imir respond? Please rate each statement in order of *priority* from 1 (low priority) to 6 (high priority). The percentage of agreement from Round 2 is indicated in the second column.

		Prioritisation Low					High
	Agreement Round 1	1	2	3	4	5	6
1. Dr Imir should adopt a sensitive and non-judgemental approach	100%						
2. Dr Imir should ask whether the parents would welcome more support	100%						
3. Dr Imir should offer treatment for Freya's ear Infection	100%						
4. Dr Imir should not be complacent just because family are 'well-known' to the team	100%						
5. Dr Imir should consider the appropriateness and accessibility of practice resources in relation to disability	100%						
6. Dr Imir should listen carefully and judge slowly	100%						
7. Dr Imir should assess Freya's general health and needs	94%						
8. Dr Imir should offer health information regarding diet and the detection of head lice	94%						
9. Dr Imir should include Freya in explanations and discussion	89%						
10. Dr Imir should explain the need to liaise with teacher and school nurse to investigate Freya's situation further	83%						
11. Dr Imir should seek the assistance of a patient advocate depending on the severity of Joanne's learning disability	78%						

This section lists statements that received less than 75% support in Round 2 or were added as comments/suggestions.

In light of the responses from others and the additional suggestions please could you now indicate your level of agreement:

	Agreement from Round 2	Strongly agree	Agree	Disagree	Strongly disagree
1. Dr Imir should consult with the Community Health Team with a view to the team completing a Common Assessment Framework (CAF) and then calling a Team Around the Child (TAC)	72%				
2. Dr Imir should assess Joanne's parenting capabilities	67%				
3. Dr Imir should view the problems presented as normal problems in children rather than inadequate or poor parenting	67%				
4. Dr Imir should assess Joanne's mental health	61%				
5. Dr Imir should seek permission to involve the wider family in care provision	56%				
6. Dr Imir should consider the impact on parents' confidence if there is a rush to assume they are inadequate	Comment from Round 2				
7. If Dr Imir has concerns about the extent of parental learning disabilities he should contact the Learning Disabilities team for a proper assessment	Suggestion from Round 2				
8. Dr Imir should arrange for the school nurse and dietician to assist the family	Comment from Round 2				
9. Dr Imir should arrange to see Joanne at another time as this consultation is about Freya	Comment from Round 2				
10. Dr Imir should consider Freya to be a child in need and arrange a CAF assessment	Comment from Round 2				
11. Dr Imir should not assume that the wider family wish to be involved.	Comment from Round 2				

Comments/suggestions relating to Vignette 3 statements:

VIGNETTE 4

Fiona Blythe-Smith is thirteen years old and has come to see her GP, Dr Johnstone. She says she fears that she is pregnant and discloses that she has been having a sexual relationship with a family member for two years. She says she wishes only to have advice about abortion and does not want any other intervention. Dr Johnstone has been the family doctor for twenty years.

How should Dr Johnstone respond?
Please rate each statement in order of priority from 1 (low priority) to 6 (high priority). The percentage of agreement from Round 2 is indicated in the second column.

		Prioritisation Low					High
	Agreement from Round 2	1	2	3	4	5	6
1. Dr Johnstone should give Fiona a pregnancy test	100%						
2. Dr Johnstone's approach should be open and non-judgemental	100%						
3. Dr Johnstone should listen carefully and judge slowly	100%						
4. Dr Johnstone should obtain information about the 'sexual relationship' without interrogating her or asking leading questions	94%						
5. Dr Johnstone should place limits on his duty to maintain confidentiality and explain to Fiona why and what he might need to disclose	94%						
6. Dr Johnstone should assess Fiona's mental capacity	89%						
7. Dr Johnstone should make an immediate referral to Social Services	89%						
8. Dr Johnstone should help prepare the GP Practice for the fallout that may follow, for example, requests, demands and complaints from other family members (seek medico-legal advice and have another colleague respond to family requests)	89%						

This section lists statements that received less than 75% support in Round 2 or were added as comments/suggestions.

In light of the responses from others and the additional suggestions please could you now indicate your level of agreement:

	Agreement from Round 2	Strongly agree	Agree	Disagree	Strongly disagree
1. Dr Johnstone should have a female chaperone during the consultation	72%				
2. Dr Johnstone should encourage Fiona to confide in someone she trusts in the family	56%				
3. Dr Johnstone should offer counselling to Fiona	50%				
4. Dr Johnstone should contact the police	50%				
5. Dr Johnstone needs to be clear what counselling is for and refer to appropriate services	Comment from Round 2				
6. Dr Johnstone should share relevant information with practice colleagues in case they are approached for information	Comment from Round 2				
7. Dr Johnstone should arrange to see Fiona in a place where they can be visually observed by another member of staff but not overheard	Suggestion from Round 2				

One statement received less than 25% agreement and this has been removed:

11. Dr Johnstone should refer Fiona to a female General Practitioner (22%)

Comments/suggestions relating to Vignette 4 statements:

Statements of principles that should guide a GP when conflicts of interests occur in the safeguarding of children.

The following statements from Round 2 received 75% or more agreement. (No action is needed from the Panel for this section: for information only. (1 person did not complete this section)

	Agreement from Round 2
1. The child's interests must be foremost – at all times all actions must be in the interest of the needs and safety of the child	94%
2. Communication is most important: if a GP ever feels unhappy with a decision that has been made, he or she should discuss it with parties involved	94%
3. GPs should be sensitive to the effect of breaking confidentiality on an individual and make each individual aware of whom information has been shared with	94%
4. GPs must adhere to the legal framework, especially the Human Rights Act, the Convention on the Rights of the Child, and advice from the GMC on the Duties of a Doctor as all provide important principles	94%
5. Local procedures, professional guidance and law make it clear that the GP is under a duty to safeguard children and share information with appropriate agencies	94%
6. To do nothing if child abuse is suspected is not an option	94%
7. Decisions must be based on evidence and analysis of the information gathered rather than assumptions	94%
8. A GP must be honest at all times when dealing with these issues	94%
9. Always record, date and time all interactions with client, what concerns are, why and the course of action taken	94%
10. Seeing children as part of the family context, and helping and supporting parents may be the best way of safeguarding children	94%
11. GPs should always be transparent and uphold professional values	94%
12. The cardinal principle is that the welfare of the child is paramount	94%
13. The GP should be prepared to admit mistakes	94%
14. GP should declare competing interests if appropriate	94%
15. GP should learn from difficult experiences relating to conflicts of interest	94%
16. GP should engage in a Significant Event Analysis	94%
17. GP should aim to make all members of the family feel respected	94%
18. GP should attempt to retain the trust of non-abusing relatives	94%
19. GPs must trust colleagues who have expertise and not try to go it alone. Services are multi-professional for a reason	89%

20. GPs should train with other professionals and get in on the local networks	89%
21. The medical principle of patient confidentiality, including that owed to the child itself, may need to be overridden in order to safeguard the child	89%
22. Seek consent where possible but if this is not possible, or consent is withheld, ensure that only issues related to the protection of the child are disclosed	89%
23. Respect different cultures and understand their belief systems	89%
24. GPs should adopt a holistic approach when making the assessment including practical, medical, psychological, social, cultural, moral and legal dimensions	89%
25. GPs must make a professional judgement as to the level of safety/health of a child	89%
26. A GPs professional judgement as to the level of safety/health of a child over-rides any social circumstances that may arise from breaking confidentiality	89%
27. GPs have a duty to support vulnerable parents in their efforts to protect and nurture their children	89%
28. GPs should follow the principles set out in the Local Safeguarding Procedures	89%
29. The number one principle is the safety of the child	89%
30. Where conflicts with the interests of adults arise, the welfare of the child is the over-riding consideration	89%
31. If other agencies are mistaken, GPs should defend the interests of their patients	89%
32. GPs should use the therapeutic relationship as much as possible to help resolve issues	89%
33. GPs should be aware that all parties have interests and rights	83%
34. GP should aim to do no harm, seeking the most therapeutic outcome	83%
35. GPs should used the named professional lead as the lynch pin, as he or she should be aware of all decisions made	78%
36. Conflict may be more apparent than real	78%
37. A GP has a statutory duty to take action when necessary to protect a child	78%
38. Seeing children as separate entities from the family, while sometimes essential, is not always so, and can do serious, long term damage	78%
39. GPs should use the therapeutic relationship as much as possible to help resolve issues	78%

This section lists statements that received less than 75% support in Round 2 or were added as comments/suggestions.

In light of the responses from others and the additional suggestions please could you now indicate your level of agreement:

	Agreement from Round 2	Strongly agree	Agree	Disagree	Strongly disagree
1. GPs should always follow local sharing information protocols	72%				
2. GPs must take into account the autonomous wishes of the individual and other peoples' needs/desires in outcome of problem	67%				
3. Patients of all ages are owed a duty of confidentiality	67%				
4. GPs should determine how the affected parties feel although this may be difficult	50%				
5. Conflict may be greater for the GP than for family members	44%				
6. A balance must always be considered between the interests of the child and the implications for the family	39%				
7. GPs should determine what the child's best interest is	39%				
8. GP should bring conflicting parties together and facilitate negotiation	33%				
9. GP should be sceptical of local procedures as not always well thought out, evidence-based or peer-reviewed	Based on comment from Round 2				
10. GP should also try to retain the trust of abusing relatives	Comment from Round 2				
11. GP should not use *primum non nocere* (first do no harm) as an excuse for inaction	Comment from Round 2				

Comments/suggestions relating to statements of principles:

The Panel's understanding of 'conflicts of interests' in the context of safeguarding children

The following statements from Round 2 received 75% or more agreement. No action is needed from the Panel for this section: for information only. (1 person did not complete this section)

	Agreement Round 2
1. Where there is a conflict between the care of a patient and the interests of a child	89%
2. Where the needs of a child are at odds with those of the parents or others	83%
3. Where there is a feeling of divided loyalties	83%
4. Where a GP is concerned about children but an adult does not want others involved	83%
5. Where the interests of an individual patient conflict with interests of other patients	83%
6. Where there is a conflict of values, for example, confidentiality and child welfare	83%
7. Where professional actions may result in a breach of trust	83%
8. Where each individual has an interest but where protecting the interests of one individual might put the other at risk	83%
9. Arises when doing what is good for one person causes harm to another	83%
10. Where putting the child's interests first, causing harm to someone may unintentionally , cause harm to the child	83%
11. Where a child does not want parental involvement	78%
12. Where the welfare, safety and interests of a child are to be decided against a background of patient confidentiality	78%

This section lists statements that received less than 75% support in Round 2 or were added as comments/suggestions.

In light of the responses from others and the additional suggestions please could you now indicate your level of agreement:

	Agreement from Round 2	Strongly agree	Agree	Disagree	Strongly disagree
1. Where a GP is concerned about children but worried that if concern is expressed the adult will not seek help	72%				
2. Where there is a conflict between the duty to obtain parental consent and also to safeguard children	72%				
3. Where the effect of a decision has a potentially negative consequence that may counterbalance the positive effect and where there is no clear answer as to the best course of action	67%				
4. Where someone in a position of trust has competing personal or professional interests making it difficult to fulfill duties impartially	67%				
5. Where proposed action of the GP is not supported by others	67%				
6. Where the needs of family members do not concur	61%				
7. Where GP experiences a dilemma because of lack of confidence in social services and the police	61%				
8. Where the interests of an individual patient conflict with interests of society	61%				
9. Where the interests of an individual patient conflict with professional values	61%				
10. Where there is a need to protect and safeguard the interests of both the adult and the child	61%				
11. Where a GP fears that intervention may cause more harm than good	50%				
12. Where there is a conflict between self-interest and the interests of others	50%				
13. Where different interests of an individual child conflict, for example, wishing abuse to stop but wanting father to remain at home	50%				

14. Where different interests of a non-abusing parent may conflict, for example, mother who wishes abuse to stop but needs partner's income	44%				
15. Where different interests of the GP may conflict, for example, safeguarding children work and meeting national targets	44%				
16. Where a child's right to be safe conflicts with the lobby for disabled parents rights	39%				
17. Where reasoning about interests result in agonies of indecision as to where duties lie	39%				
18. Where reasoning about interests result in agonies of indecision as to where duties lie	39%				
19. Where a number of viewpoints are valid and there is a genuine dilemma to be addressed about how to proceed	Comment from Round 2				

One statement received less than 25% agreement in Round 2 and this has been removed:

31. I find the concept of 'safeguarding' so hazy that this question is impossible to answer (17%)

Comments/suggestions relating to statements of conflicts of interest:

Thank You for Completing the Round 3 Questionnaire

Round 3 Questionnaire APPENDIX a *(provided as feedback with Round 3)*

Round 2 findings (mean scores) regarding seriousness and urgency of each vignette:
1 = most serious and most urgent & 6 = not serious and not urgent

	Vignette 1	Vignette 2	Vignette 3	Vignette 4
Serious	1.28	1.44	3.67	1.00
Urgent	1.50	1.67	3.72	1.44

APPENDIX b

(This table is included separately as Appendix 15: To Whom or Where should GPs Go to for Professional Advice in Relation to Conflicts of Interests and Safeguarding Children)

Appendix 7iv: Delphi questionnaire - Round 4

Dear Panel Member,

Thank you very much for completing the previous Questionnaires. We now invite you to complete the 4th and final Questionnaire. We have collated the Panel's responses in relation to the statements in the Round 3 questionnaire. Statements that achieved 75% agreement or greater have been retained and those achieving under 75% removed. You are provided with feedback relating to the prioritisation scores.

Regarding the four **vignettes** you are now invited to indicate, in relation to each of the statements, which **response time** you think most appropriate by putting the relevant number in the box as follows:

1 = By the end of the consultation
2 = By the end of that day's surgery
3 = By the end of the following day
4 = Over a longer period
5 = Response time doesn't apply

For new vignette statements you are asked also to rate **priority** from 1 (low priority) to 6 (high priority) and also response time. See example below:

	Agreement Round 2	**Round 3 Priorities (average) 1 = low 6 = high**	**Response time Add 1, 2, 3, 4 or 5**
1. Dr Clarke should assess the nature and severity of Comfort's mental health problems	100%	5.71	2

In relation to **principles that should guide a GP when conflicts of interests occur in the safeguarding of children** you are invited to rate these on a scale of 1 (unimportant) to 10 (highly important) by inserting the relevant number in the box.

Finally, you are invited to select 3 statements that best capture your **understanding of conflicts of interests**.

Again, we invite you to respond as fully and frankly as possible. All of the contributions have been anonymised. If you have any questions about the Delphi questionnaire or any other aspects of the project please contact: Ms Rozalind Neatby, Research Programmes Administrator, School of Social Work, Kingston University, Kingston Hill KT2 7LB. Phone: 0208 547 8669

Yours sincerely,

The Project Team

VIGNETTE 1

Dr Clarke is a GP, working in a busy inner city practice, is coming towards the end of the morning clinic and the next patient is Comfort Kyamatuuku, a 34 year old woman, who has a history of depression. She is a single parent of two pre-school children and has brought them along to the surgery. Comfort tells the GP that she has difficulty getting up in the morning and with everyday activities such as shopping and cooking. She says she feels like killing herself and has thought about how she might go about this. She says she does not want to be admitted to hospital as 'I'd be wasting their time'.

Indicate which GP **response time** you think most appropriate, in relation to each statement, by putting the relevant number in the box as follows:

1 = By the end of the consultation
2 = By the end of that day's surgery
3 = By the end of the following day
4 = Over a longer period
5 = Response time doesn't apply

	Agreement Round 2	Round 3 Priorities (average) 1 = low 6 = high	Response time Add 1, 2, 3, 4 or 5
1. Dr Clarke should assess the nature and severity of Comfort's mental health problems	100%	5.71	
2. Dr Clarke should assess risks to Comfort, for example, in relation to self-harm and suicide	100%	5.79	
3. Dr Clarke should identify appropriate interventions in response to Comfort's mental health problems	100%	5.50	
4. Dr Clarke should assess risks to the children arising from Comfort's mental health problems	100%	5.71	
5. Dr Clarke should obtain information about family and social support for Comfort and her children	100%	5.29	
6. Dr Clarke should make time to establish a rapport with Comfort and listen to her carefully	100%	5.36	
7. Dr Clarke should use professional judgement and not jump to conclusions	100%	5.64	
8. Dr Clarke should complete contemporaneous, timed and dated notes clearly detailing his concerns and the action he will take	100%	5.50	
9. Dr Clarke should assess Comfort's mental capacity	94%	5.36	
10. Dr Clarke should assess the well-being of Comfort's children	94%	5.14	
11. Dr Clarke should seek Comfort's permission to discuss her situation with other professionals	94%	5.14	

12. Dr Clarke should ask the Health Visitor to assess the home situation	94%	5.14	
13. Dr Clarke should inform Comfort of the limits of confidentiality, that is, what information may be shared with whom, why and what might follow from this	94%	5.64	
14. Dr Clarke should gain a broader picture and understanding of how Comfort is feeling and responding	89%	4.79	
15. Dr Clarke should 'seize the moment'. This opportunity to help the family may not arise again	89%	5.21	
16. Dr Clarke should listen carefully and judge slowly	89%	5.14	
17. Dr Clarke should consider whether or not Comfort needs to be detained under a section of the Mental Health Act	83%	5.00	
18. Dr Clarke should discuss his concerns with Comfort and explain that he needs to make a referral to Social Services	78%	5.14	
19. Dr Clarke should refer Comfort and her children to Social Services	78%	4.79	

The statements below had more than 75% support in Round 3 and we invite you now to prioritise them and to indicate response time as above.

	Agreement Round 2	Priorities (average) 1 = low 6 = high	Response time see above: 1, 2, 3, 4 or 5
1. Dr Clarke should involve the Health Visitor on an on-going basis not merely on a one-off home assessment	100%		
2. The responses to some statements depend on those from others – each cannot be addressed in isolation	93%		
3. Dr Clarke should have an informal discussion with a senior social worker to talk around the problem rather than a straightforward referral	86%		
4. In responding to Comfort's cultural needs Dr Clarke should not make assumptions and offer Comfort choice	79%		

Statements achieving less than 75% and removed:

1. Dr Clarke should respond appropriately to Comfort's cultural needs by, for example, making a referral to a cross-cultural psychiatrist *(64%)*
2. If Comfort's first language is not English, Dr Clarke should arrange another appointment and involve an interpreter *(64%)*
3. Dr Clarke should try to carry out some form of assessment, possibly using online translation tools *(29%)*
4. Dr Clarke should decide if the referral is for a child in need or a child in need of protection from significant harm *(64%)*

Final comments relating to Vignette 1 (The box will expand as you type)

VIGNETTE 2

Elaine O'Neill is a 19 year old woman with a history of alcohol and drug abuse visits her GP, Dr Amoah, for an antenatal appointment. She has two children under 5. Dr Amoah notices extensive bruising on Elaine's forearms and legs. When asked about this, Elaine says 'Oh I keep walking into things', She mentions, in passing, that her new partner thinks that her two year old son (also Dr Amoah's patient) is deliberately 'very naughty' and regularly gives him a 'good hiding'. She says her partner comes from a culture that believes in 'discipline' and that she agrees that her son needs to be 'chastised'.

Indicate which GP **response time** you think most appropriate, in relation to each statement, by putting the relevant number in the box as follows:

1 = By the end of the consultation
2 = By the end of that day's surgery
3 = By the end of the following day
4 = Over a longer period
5 = Response time doesn't apply

	Agreement Round 1	**Round 3 Priorities (average) 1 = low 6 = high**	**Response time Add 1, 2, 3, 4 or 5**
1. Dr Amoah should assess the severity and impact of Elaine's drug problems on her pregnancy and ability to care for her children	100%	5.59	
2. Dr Amoah should ask questions about 'chastisement' of the 2 year old child and consider the possibility of physical abuse	100%	5.86	
3. Dr Amoah should consider the consequences of disclosing information, for example, increased violence	100%	5.36	
4. Dr Amoah should investigate the causes of bruising on Elaine's forearms and legs	94%	5.14	
5. Dr Amoah should make time to establish a rapport with Elaine and listen to her carefully	94%	5.29	
6. Dr Amoah should seek additional information from the Health Visitor	94%	5.43	
7. Dr Amoah should listen carefully and judge slowly	94%	5.21	
8. Dr Amoah should document his concerns fully, clearly and contemporaneously including an action plan	94%	5.50	
9. Dr Amoah should provide information and advice regarding domestic violence, for example, information about Women's Aid refuges and an exit plan	89%	5.36	

10. Dr Amoah should discuss his concerns with Elaine and explain that he needs to make a referral to Social Services	89%	5.36	
11. Dr Amoah should discuss treatment options, regarding her drug and alcohol problems, with Elaine	83%	5.36	

The statements below had more than 75% support in Round 3 and we invite you now to prioritise them and to indicate response time as above.

	Agreement Round 3	**Priorities (average) 1 = low 6 = high**	**Response time Add 1, 2, 3, 4 or 5**
1. Dr. Amoah needs to manage this situation within an interagency framework	100%		
2. Dr Amoah needs to discuss this situation with the midwife	100%		
3. Dr Amoah should be aware that asking questions about 'chastisement' is a potentially risky strategy and Elaine may walk out if challenged	86%		
4. Dr Amoah should refer to Social Services as a matter of urgency	79%		
5. Dr Amoah must be very clear about agreed outcomes should he have an informal discussion with social worker	79%		
6. Dr Amoah should draft an action plan in conjunction with other professionals	79%		
7. Dr Amoah should ask the Health Visitor to visit the family urgently to assess the children and the home environment	79%		

Statements achieving less than 75% and removed:

1. Dr Amoah should ask Elaine to bring her two children to the surgery later that day or the next *(64%)*
2. Dr Amoah should discuss childcare options, for example, nursery places if no childcare is currently being accessed *(50%)*
3. Dr Amoah should speak to Children's Social Care whilst the mother is still at the surgery *(57%)*
4. Dr Amoah should see the children immediately, not later on or the next day *(36%)*
5. Discussing childcare options is not the GP's role – refer if necessary to Health Visitor or Social Worker *(36%)*

Final comments relating to Vignette 2

VIGNETTE 3

Joanne Perkins brings her eight year old daughter (Freya) to see the GP, Dr Imir. Joanne and her partner, Robert, have learning disabilities and are well-known to the community health team. Joanne tells Dr Imir that she has been very worried about her daughter as she has been complaining of pain in her ears. He observes that Freya is overweight and appears to have head lice. On investigation Dr Imir diagnoses an ear infection.

Indicate which GP **response time** you think most appropriate, in relation to each statement, by putting the relevant number in the box as follows:

1 = By the end of the consultation
2 = By the end of that day's surgery
3 = By the end of the following day
4 = Over a longer period
5 = Response time doesn't apply

	Agreement from Round 1	Round 3 Priorities (average) 1 = low 6 = high	Response time Add 1, 2, 3, 4 or 5
1. Dr Imir should adopt a sensitive and non-judgemental approach	100%	5.21	
2. Dr Imir should ask whether the parents would welcome more support	100%	5.21	
3. Dr Imir should offer treatment for Freya's ear infection	100%	5.36	
4. Dr Imir should not be complacent just because family are 'well-known' to the team	100%	5.21	
5. Dr Imir should consider the appropriateness and accessibility of practice resources in relation to disability	100%	4.71	
6. Dr Imir should listen carefully and judge slowly	100%	5.21	
7. Dr Imir should assess Freya's general health and needs	94%	5.00	
8. Dr Imir should offer health information regarding diet and the detection of head lice	94%	4.86	
9. Dr Imir should include Freya in explanations and discussion	89%	5.14	
10. Dr Imir should explain the need to liaise with teacher and school nurse to investigate Freya's situation further	83%	4.50	
11. Dr Imir should seek the assistance of a patient advocate depending on the severity of Joanne's learning disability	78%	4.21	

The statements below had more than 75% support in Round 3 and we invite you now to prioritise them and to indicate response time as above.

	Agreement from Round 3	Priorities (average) 1 = low 6 = high	Response time Add 1, 2, 3, 4 or 5
1. Dr Imir should not assume that the wider family wish to be involved	93%		
2. If Dr Imir has concerns about the extent of parental learning disabilities he should contact the Learning Disabilities team for a proper assessment	93%		
3. Dr Imir should arrange for the school nurse and dietician to assist the family	86%		
4. Dr Imir should consider the impact on parents' confidence if there is a rush to assume they are inadequate	79%		

Statements achieving less than 75% and removed:

1. Dr Imir should consult with the Community Health Team with a view to the team completing a Common Assessment Framework (CAF) and then calling a Team Around the Child (TAC) *(71%)*
2. Dr Imir should assess Joanne's parenting capabilities *(43%)*
3. Dr Imir should view the problems presented as normal problems in children rather than inadequate or poor parenting *(57%)*
4. Dr Imir should assess Joanne's mental health *(36%)*
5. Dr Imir should seek permission to involve the wider family in care provision *(43%)*
6. Dr Imir should arrange to see Joanne at another time as this consultation is about Freya *(57%)*
7. Dr Imir should consider Freya to be a child in need and arrange a CAF assessment *(64%)*

Final comments relating to Vignette 3

VIGNETTE 4

Fiona Blythe-Smith is thirteen years old and has come to see her GP, Dr Johnstone. She says she fears that she is pregnant and discloses that she has been having a sexual relationship with a family member for two years. She says she wishes only to have advice about abortion and does not want any other intervention. Dr Johnstone has been the family doctor for twenty years.

Identify which GP **response time** you think most appropriate, in relation to each statement, by putting the relevant number in the box as follows:

1 = By the end of the consultation
2 = By the end of that day's surgery
3 = By the end of the following day
4 = Over a longer period
5 = Response time doesn't apply

	Agreement from Round 1	Round 3 Priorities (average) 1 = low 6 = high	Response time Add 1, 2, 3, 4 or 5
1. Dr Johnstone should give Fiona a pregnancy test	100%	6.00	
2. Dr Johnstone's approach should be open and non-judgemental	100%	5.93	
3. Dr Johnstone should listen carefully and judge slowly	100%	5.64	
4. Dr Johnstone should obtain information about the 'sexual relationship' without interrogating her or asking leading questions	94%	5.57	
5. Dr Johnstone should place limits on his duty to maintain confidentiality and explain to Fiona why and what he might need to disclose	94%	5.86	
6. Dr Johnstone should assess Fiona's mental capacity	89%	5.00	
7. Dr Johnstone should make an immediate referral to Social Services	89%	5.43	
8. Dr Johnstone should help prepare the GP practice for the fallout that may follow, for example, requests, demands and complaints from other family members (seek medico-legal advice and have another colleague respond to family requests)	89%	4.71	

The statements below had more than 75% support in Round 3 and we invite you now to prioritise them and to indicate response time as above.

	Agreement from Round 3	Priorities (average) 1 = low 6 = high	Response time Add 1, 2, 3, 4 or 5
1. Dr Johnstone needs to be clear what counselling is for and refer to appropriate services	100%		
2. Dr Johnstone should have a female chaperone during the consultation	86%		
3. Dr Johnstone should share relevant information with practice colleagues in case they are approached for information	86%		

Statements achieving less than 75% and removed:

1. Dr Johnstone should encourage Fiona to confide in someone she trusts in the family *(50%)*
2. Dr Johnstone should offer counselling to Fiona *(57%)*
3. Dr Johnstone should contact the police *(43%)*
4. Dr Johnstone should arrange to see Fiona in a place where they can be visually observed by another member of staff but not overheard *(50%)*

Final comments relating to Vignette 4

This table relates to statements of principles that should guide a GP when conflicts of interests occur in the safeguarding of children. These statements had over 75% agreement.

The percentage of agreement in Rounds 2 & 3 is indicated in the second column.

Please rate each statement from 1 (unimportant) **to 10** (highly important) **in the third column.**

	Agreement from Rounds 2 & 3	**Rate from1 (unimportant) to 10 (highly important)**
1. The child's interests must be foremost – at all times all actions must be in the interest of the needs and safety of the child	94%	
2. Communication is most important: if a GP ever feels unhappy with a decision that has been made, he or she should discuss it with parties involved	94%	
3. GPs should be sensitive to the effect of breaking confidentiality on an individual and make each individual aware of whom information has been shared with	94%	
4. GPs must adhere to the legal framework, especially the Human Rights Act, the Convention on the Rights of the Child, and advice from the GMC on the Duties of a Doctor as all provide important principles	94%	
5. Local procedures, professional guidance and law make it clear that the GP is under a duty to safeguard children and share information with appropriate agencies	94%	
6. To do nothing if child abuse is suspected is not an option	94%	
7. Decisions must be based on evidence and analysis of the information gathered rather than assumptions	94%	
8. A GP must be honest at all times when dealing with these issues	94%	
9. Always record, date and time all interactions with client, what concerns are, why and the course of action taken	94%	
10. Seeing children as part of the family context, and helping and supporting parents may be the best way of safeguarding children	94%	
11. GPs should always be transparent and uphold professional values	94%	
12. The cardinal principle is that the welfare of the child is paramount	94%	
13. The GP should be prepared to admit mistakes	94%	

14. GP should declare competing interests if appropriate	94%	
15. GP should learn from difficult experiences relating to conflicts of interest	94%	
16. GP should engage in a Significant Event Analysis	94%	
17. GP should aim to make all members of the family feel respected	94%	
18. GP should attempt to retain the trust of non-abusing relatives	94%	
19. GP's should always follow local sharing information protocols	93%	
20. GPs must trust colleagues who have expertise and not try to go it alone. Services are multi-professional for a reason	89%	
21. GPs should train with other professionals and get in on the local networks	89%	
22. The medical principle of patient confidentiality, including that owed to the child itself, may need to be overridden in order to safeguard the child	89%	
23. Seek consent where possible but if this is not possible, or consent is withheld, ensure that only issues related to the protection of the child are disclosed	89%	
24. Respect different cultures and understand their belief systems	89%	
25. GPs should adopt a holistic approach when making the assessment including practical, medical, psychological, social, cultural, moral and legal dimensions	89%	
26. GPs must make a professional judgement as to the level of safety/health of a child	89%	
27. A GPs professional judgement as to the level of safety/health of a child overrides any social circumstances that may arise from breaking confidentiality	89%	
28. GPs have a duty to support vulnerable parents in their efforts to protect and nurture their children	89%	
29. GPs should follow the principles set out in the Local Safeguarding Procedures	89%	
30. The number one principle is the safety of the child	89%	
31. Where conflicts with the interests of adults arise, the welfare of the child is the over-riding consideration	89%	
32. If other agencies are mistaken, GPs should defend the interests of their patients	89%	
33. GPs should use the therapeutic relationship as much as possible to help resolve issues	89%	

34. GPs must take into account the autonomous wishes of the individual and other peoples' needs/ desires in outcome of problem	86%	
35. GP should not use *primum non nocere* (first do no harm) as an excuse for inaction	86%	
36. GPs should be aware that all parties have interests and rights	83%	
37. GP should aim to do no harm, seeking the most therapeutic outcome	83%	
38. GPs should used the named professional lead as the lynch pin, as he or she should be aware of all decisions made	78%	
39. Conflict may be more apparent than real	78%	
40. A GP has a statutory duty to take action when necessary to protect a child	78%	
41. Seeing children as separate entities from the family, while sometimes essential, is not always so, and can do serious, long term damage	78%	
42. GPs should use the therapeutic relationship as much as possible to help resolve issues	78%	

These statements received less than 75% support and were removed:

1. GPs should always follow local sharing information protocols *(72%)*
2. Patients of all ages are owed a duty of confidentiality *(71%)*
3. GPs should determine how the affected parties feel although this may be difficult *(71%)*
4. Conflict may be greater for the GP than for family members *(36%)*
5. A balance must always be considered between the interests of the child and the implications for the family *(29%)*
6. GPs should determine what the child's best interest is *(57%)*
7. GP should bring conflicting parties together and facilitate negotiation *(14%)*
8. GP should be sceptical of local procedures as not always well thought out, evidence-based or peer-reviewed *(14%)*
9. GP should also try to retain the trust of abusing relatives *(29%)*

Final comments relating to principles that should guide a GP when conflicts of interests occur in the safeguarding of children

The following statements summarising the panel's understanding of 'conflicts of interests' in the context of safeguarding children had over 75% support.

The percentage of agreement from Rounds 2 & 3 is indicated in the second column.

Please now select **3 statements** that best capture what you understand by 'conflicts of interests' by placing an X in the third column.

	Agreement from Rounds 2 & 3	Mark (X) 3 statements only
1. Where there is a conflict between the care of a patient and the interests of a child	89%	
2. Where the effect of a decision has a potentially negative consequence that may counterbalance the positive effect and where there is no clear answer as to which is the best course of action	86%	
3. Where the needs of a child are at odds with those of the parents or others	83%	
4. Where there is a feeling of divided loyalties	83%	
5. Where a GP is concerned about children but an adult does not want others involved	83%	
6. Where the interests of an individual patient conflict with interests of other patients	83%	
7. Where there is a conflict of values, for example, confidentiality and child welfare	83%	
8. Where professional actions may result in a breach of trust	83%	
9. Where each individual has an interest but where protecting the interests of one individual might put the other at risk	83%	
10. Arises when doing what is good for one person causes harm to another	83%	
11. Where putting the child's interests first, causing harm to someone may unintentionally cause harm to the child	83%	
12. Where a child does not want parental involvement	78%	
13. Where the welfare, safety and interests of a child are to be decided against a background of patient confidentiality	78%	

These statements received less than 75% support and were removed:

Where a GP is concerned about children but worried that if concern is expressed the adult will not seek help *(57%)*

Where there is a conflict between the duty to obtain parental consent and also to safeguard children *(57%)*

Where someone in a position of trust has competing personal or professional interests making it difficult to fulfil duties impartially *(57%)*

Where proposed action of the GP is not supported by others *(50%)*

Where the needs of family members do not concur *(57%)*

Where GP experiences a dilemma because of lack of confidence in social services and the police *(21%)*

Where the interests of an individual patient conflict with interests of society *(50%)*

Where the interests of an individual patient conflict with professional values *(71%)*

Where there is a need to protect and safeguard the interests of both the adult and the child *(57%)*

Where a GP fears that intervention may cause more harm than good *(50%)*

Where there is a conflict between self-interest and the interests of others *(36%)*

Where different interests of an individual child conflict, for example, wishing abuse to stop but wanting father to remain at home *(43%)*

Where reasoning about interests result in agonies of indecision as to where duties lie *(14%)*

Where different interests of a non-abusing parent may conflict, for example, mother who wishes abuse to stop but needs partner's income *(50%)*

Where different interests of the GP may conflict, for example, safeguarding children work and meeting national targets *(43%)*

Where a child's right to be safe conflicts with the lobby for disabled parents rights *(36%)*

Where a number of viewpoints are valid and there is a genuine dilemma to be addressed about how to proceed *(57%)*

Final comments relating to your understanding of 'conflicts of interests' in the context of safeguarding children

Thank You for Completing the 4th and Final Questionnaire

Appendix 8: Response Rates to the Delphi Process

Response rates to each of the rounds in the Delphi process were 93% in Round 1 (25 responses)), 72% in Round 2 (18 responses), 56% (14 responses) in Round 3 and 56% (14 responses) in Round 4. As has occurred in other Delphi panels, some participants dropped out of intervening rounds and returned a response in the final round.

Responses from the GPs within the Panel were as follows: six responses in round 1, four in round 2, two in round 3 and three in round 4. The rate of response overall is higher than the response rates in some Delphi studies but lower than in others. Beattie et al (2004) reported 66% in Round 1, 83% in Round 2 and 81% in Round 3 of study in nursing and midwifery whilst Cross (2001) reported a final response of 43% in a study in physiotherapy. The numbers overall in the final round (14) were small but nevertheless can be taken as a valid consensus view that can be usefully juxtaposed against the views of an individual or an individual profession; it could not necessarily be argued that another group assembled similarly would produce the same sets of statements.

From the analysis of the iterations, respondents expressed their views in a number of ways, by signifying agreement or not to statements, by not returning questionnaires and by partially completing questionnaires. It is clear also that each of the respondents held strong views on what a GP “should” do, and accompanied their responses to the Delphi questionnaires with considerable and considered comments:

- on what they were being asked to do in the Delphi process,
- on the limitations of vignettes
- qualifying their responses to the questionnaires,
- providing significant evidence on which they based their judgements,
- emphasizing the importance of holistic and multi-agency approaches, and
- making quite significant criticisms on the behaviour or judgements of other professionals as individuals and groups.

Their commentary extended beyond the focus on GPs, generating a bank of “informed wisdom” and drawing on their specific knowledge, which could be of value in the development of Practice Guidance.

Appendix 9: Delphi Panel's understanding of 'conflicts of interests' in the context of safeguarding children

The following statements from the Panel show the rating of each statement, from 1 (least favoured) to 10 (highly favoured). An asterisk indicates that a statement was one of the top favoured four statements.

	Agreement Rounds 2 & 3	Most favoured statements Round 4
1. Where there is a conflict between the care of a patient and the interests of a child	89%	9*
2. Where the effect of a decision has a potentially negative consequence that may counterbalance the positive effect and where there is no clear answer as to which is the best course of action	86%	4
6. Where the interests of an individual patient conflict with interests of other patients	83%	6*
3. Where the needs of a child are at odds with those of the parents or others	83%	5*
9. Where each individual has an interest but where protecting the interests of one individual might put the other at risk	83%	5*
8. Where professional actions may result in a breach of trust	83%	4
5. Where a GP is concerned about children but an adult does not want others involved	83%	3
7. Where there is a conflict of values, for example, confidentiality and child welfare	83%	3
10. Arises when doing what is good for one person causes harm to another	83%	3
11. Where putting the child's interests first, causing harm to someone may unintentionally , cause harm to the child	83%	3
4. Where there is a feeling of divided loyalties	83%	1
13. Where the welfare, safety and interests of a child are to be decided against a background of patient confidentiality	78%	1
12. Where a child does not want parental involvement	78%	0

Appendix 10: Delphi findings: Principles that should guide a GP when conflicts of interests occur in the safeguarding of children.

The following statements of principles that should guide a GP when conflicts of interests occur in the safeguarding of children achieved over 75% agreement. The Panel rated each statement from 1 (unimportant) to 10 (highly important). The percentage of agreement in Rounds 2 & 3 is indicated in the second column.

	Agreement	Importance
1. The number one principle is the safety of the child	89%	10.00
2. To do nothing if child abuse is suspected is not an option	94%	9.21
3. The cardinal principle is that the welfare of the child is paramount	94%	9.21
4. Where conflicts with the interests of adults arise, the welfare of the child is the over-riding consideration	89%	9.21
5. GPs should always be transparent and uphold professional values	94%	9.14
6. A GP must be honest at all times when dealing with these issues	94%	9.07
7. The GP should be prepared to admit mistakes	94%	9.07
8. The child's interests must be foremost – at all times all actions must be in the interest of the needs and safety of the child	94%	9.00
9. Local procedures, professional guidance and law make it clear that the GP is under a duty to safeguard children and share information with appropriate agencies	94%	9.00
10. Always record, date and time all interactions with client, what concerns are, why and the course of action taken	94%	9.00
11. GPs must adhere to the legal framework, especially the Human Rights Act, the Convention on the Rights of the Child, and advice from the GMC on the Duties of a Doctor as all provide important principles	94%	8.93
12. GP should learn from difficult experiences relating to conflicts of interest	94%	8.79
13. Seek consent where possible but if this is not possible, or consent is withheld, ensure that only issues related to the protection of the child are disclosed	89%	8.79
14. GPs must trust colleagues who have expertise and not try to go it alone. Services are multi-professional for a reason	89%	8.71
15. Decisions must be based on evidence and analysis of the information gathered rather than assumptions	94%	8.57
16. GPs should train with other professionals and get in on the local networks	89%	8.57

17. The medical principle of patient confidentiality, including that owed to the child itself, may need to be overridden in order to safeguard the child	89%	8.50
18. GP should declare competing interests if appropriate	94%	8.43
19. GPs should follow the principles set out in the Local Safeguarding Procedures	89%	8.43
20. GPs should be aware that all parties have interests and rights	83%	8.43
21. Seeing children as part of the family context, and helping and supporting parents may be the best way of safeguarding children	94%	8.36
22. GP should attempt to retain the trust of non-abusing relatives	94%	8.36
23. GP's should always follow local sharing information protocols	93%	8.29
24. GP should not use *primum non nocere* (first do no harm) as an excuse for inaction	86%	8.29
25. Communication is most important: if a GP ever feels unhappy with a decision that has been made, he or she should discuss it with parties involved	94%	8.21
26. GP should aim to make all members of the family feel respected	94%	8.21
27. A GP has a statutory duty to take action when necessary to protect a child	78%	8.14
28. GP should engage in a Significant Event Analysis	94%	8.07
29. GPs must make a professional judgement as to the level of safety/health of a child	89%	8.07
30. A GPs professional judgement as to the level of safety/health of a child overrides any social circumstances that may arise from breaking confidentiality	89%	8.07
31. GPs have a duty to support vulnerable parents in their efforts to protect and nurture their children	89%	7.93
32. GP should aim to do no harm, seeking the most therapeutic outcome	83%	7.86
33. Seeing children as separate entities from the family, while sometimes essential, is not always so, and can do serious, long term damage	78%	7.86
34. GPs should adopt a holistic approach when making the assessment including practical, medical, psychological, social, cultural, moral and legal dimensions	89%	7.79
35. Respect different cultures and understand their belief systems	89%	7.71

36. GPs should use the therapeutic relationship as much as possible to help resolve issues	89%	7.64
37. GPs should used the named professional lead as the lynch pin, as he or she should be aware of all decisions made	78%	7.64
38. If other agencies are mistaken, GPs should defend the interests of their patients	89%	7.50
39. GPs must take into account the autonomous wishes of the individual and other peoples' needs/ desires in outcome of problem	86%	7.14
40. GPs should be sensitive to the effect of breaking confidentiality on an individual and make each individual aware of whom information has been shared with	94%	6.89
41. Conflict may be more apparent than real	78%	6.86
42. GP's should use the therapeutic relationship as much as possible to help resolve issues	78%	6.57

Appendix 11: Delphi findings: Vignette statements achieving less than 75% and removed

Vignette 1

1. Dr Clarke should respond appropriately to Comfort's cultural needs by, for example, making a referral to a cross-cultural psychiatrist *(64%)*
2. If Comfort's first language is not English, Dr Clarke should arrange another appointment and involve an interpreter *(64%)*
3. Dr Clarke should try to carry out some form of assessment, possibly using online translation tools *(29%)*
4. Dr Clarke should decide if the referral is for a child in need or a child in need of protection from significant harm *(64%)*

Vignette 2

1. Dr Amoah should ask Elaine to bring her two children to the surgery later that day or the next *(64%)*
2. Dr Amoah should discuss childcare options, for example, nursery places if no childcare is currently being accessed *(50%)*
3. Dr Amoah should speak to Children's Social Care whilst the mother is still at the surgery *(57%)*
4. Dr Amoah should see the children immediately, not later on or the next day *(36%)*
5. Discussing childcare options is not the GP's role – refer if necessary to Health Visitor or Social Worker *(36%)*

Vignette 3

1. Dr Imir should consult with the Community Health Team with a view to the team completing a Common Assessment Framework (CAF) and then calling a Team Around the Child (TAC) *(71%)*
2. Dr Imir should assess Joanne's parenting capabilities *(43%)*
3. Dr Imir should view the problems presented as normal problems in children rather than inadequate or poor parenting *(57%)*
4. Dr Imir should assess Joanne's mental health *(36%)*
5. Dr Imir should seek permission to involve the wider family in care provision *(43%)*
6. Dr Imir should arrange to see Joanne at another time as this consultation is about Freya *(57%)*
7. Dr Imir should consider Freya to be a child in need and arrange a CAF assessment *(64%)*

Vignette 4

1. Dr Johnstone should encourage Fiona to confide in someone she trusts in the family *(50%)*
2. Dr Johnstone should offer counselling to Fiona *(57%)*
3. Dr Johnstone should contact the police *(43%)*
4. Dr Johnstone should arrange to see Fiona in a place where they can be visually observed by another member of staff but not overheard *(50%)*

Appendix 12: Delphi findings: How should the GP respond in relation to each of the vignettes

A grounded classification was developed by the researchers for the statements agreed by the Panel (on how the GP should respond in each of the vignettes) as either an *Action* or an *Approach.* Terms in rounded brackets provide additional detail, whilst those in squared brackets indicate the particular statement(s) concerned.

Each table presents the classification in response to the timeframe for the GP responses, as agreed by the Panel: *by end of the consultation*, *by the end of that day's surgery*, *by the end of the following day*, and *over a longer period.*

Responses *by end of the consultation*

Classification	Vignette 1	Vignette 2	Vignette 3	Vignette 4
Action: Assessing Informing, Explaining, Discussing, Referring, Offering treatment, Offering support, Documenting, Gaining consent.	Assessment of Comfort (risk, mental health problems, re. detention, mental capacity) [*1, 6, 9, 11*] Assessment of children (risk, well-being) [*3*, *12*] Informing (limits of confidentiality, need for referral) *[2, 8*] Documentation [*5*] Gain consent to discuss [*7*]	Assessment of child(ren)'s situation [*1, 3*] Assessment of Elaine (bruising) [*6*] Documentation [*2*] Explain need for referral to Social Services [*5*] Discuss treatment options [*8*]	Offer treatment [*1*] Offer support [*2*] Include child in discussion [*3*] Offer health information [*4*] Assessment of child (general health) [*5*]	Explanation re. limits of confidentiality [*1*] Assessment (Obtain information, pregnancy test, mental capacity) [*2, 3, 5*] Referral to Social Services [*4*]
Approach: Professional judgement, Consideration of consequences, Making time, Sensitivity, openness and being non-judgemental Non-complacency	Use professional judgement [*4*] Make time to establish rapport [*10*]	Consider consequences of disclosure [*4*] Make time to establish rapport [*7*] Awareness of consequences of asking questions [*9*]	Consider impact on parents' confidence [*6*] Adopt a sensitive and non-judgemental approach [*7*] Do not be complacent just because family are well-known [*8*]	Female chaperone [*6*] Open and non-judgemental [*7*]

Appendix 12: Delphi findings: How should the GP respond in relation to each of the vignettes

Responses *by the end of that day's surgery*

Classification	Vignette 1	Vignette 2	Vignette 3	Vignette 4
Action Identify interventions, Referral, Assessment, Informal discussion, Share information, Prepare for fallout	Identify interventions re. Comfort [*1*] Refer to Social Services [*2*] Assessment re family and social support [*3*] Ask Health Visitor to assess [*4*] Have informal talk with Social Worker [*6*]	Refer to Social Services [*1*] Discuss with midwife [*2*] Seek additional information from Health Visitor [*3*] Ask Health Visitor to visit and assess urgently [*4*]	n/a	Share information with practice colleagues [*1*] Help prepare practice for fallout [*2*]
Approach Involvement of other professionals, Clarity about outcomes, Interagency working	Involve Health Visitor on on-going basis [*5*]	Be clear about outcomes re. discussion with Social Worker [*5*] Manage within interagency framework [*6*]		

Responses *by the end of the following day*

Classification	Vignette 1	Vignette 2	Vignette 3	Vignette 4
Action Informing and advising Action planning Inter-professional working Assessment Referral	n/a	Provide information and advice [*1*] Draft action plan with other professionals [*2*]	If concerns contact Learning Disability team for assessment [*1*]	Refer to appropriate counselling services [*1*]
Approach Clarity re. intervention				Needs to be clear what counselling is for [*1*]

Appendix 12: Delphi findings: How should the GP respond in relation to each of the vignettes

Responses *over a longer period*

Classification	Vignette 1	Vignette 2	Vignette 3	Vignette 4
Action Assessment Explanation Liaison Co-ordination Advocacy services	Assessment (broader picture of feelings and responses) [*1*]	n/a	Explanation re need for liaison [*1*] Arrange for other professionals to assist family [*3*] Seek assistance of advocate [*4*]	n/a
Approach Consideration of resources			Consider appropriateness and accessibility of resources [*2*]	

Appendix 13: Delphi findings: GP responses and timing in relation to vignettes

This table provides the full statements sorted by vignettes and timeframes used for Appendix 12. The final table shows responses deemed not applicable by the Panel members.

By the end of this consultation

Vignette 1 (Dr. Clarke)	**Vignette 2** (Dr. Amoah)	**Vignette 3** (Dr Imir)	**Vignette 4** (Dr Johnstone)
1. Dr. should assess risks to Comfort, for example, in relation to self-harm and suicide	1.Dr. should ask questions about 'chastisement' of the 2-year-old child and consider the possibility of physical abuse	1. Dr. should offer treatment for Freya's ear infection	1. Dr. Should place limits on his duty to maintain confidentiality and explain to Fiona why and what he might need to disclose
2. Dr. should inform Comfort of the limits of confidentiality, that is, what information may be shared with whom, why and what might follow from this.	2. Dr. should document his concerns fully, clearly and contemporaneously including an action plan.	2. Dr. should ask whether the parents would welcome more support	2. Dr should obtain information about the 'sexual relationship' without interrogating her or asking leading questions
3. Dr should assess risks to the children arising from Comfort's mental health problems	3: Dr. should assess the severity and impact of Elaine's drug problems on her pregnancy and ability to care for her children	3. Dr. should include Freya in explanations and discussion	3. Dr. should give Fiona a pregnancy test
4. Dr. should use professional judgement and not jump to conclusions	4. Dr. should consider the consequences of disclosing information, for example, increased violence	4. Dr. should offer health information regarding diet and the detection of head lice	4. Dr. should make an immediate referral to Social Services
5. Dr. should complete contemporaneous, timed and dated notes clearly detailing his concerns and the action he will take	5. Dr. should discuss his concerns with Elaine and explain that he needs to make a referral to Social Services	5. Dr. should assess Freya's general health and needs	5. Dr. should assess Fiona's mental capacity
6. Dr. should assess the nature and severity of Comfort's mental health problem	6. Dr. should investigate the causes of bruising on Elaine's forearms and legs	6. Dr. should consider the impact on parents' confidence if there is a rush to assume they are inadequate	6. Dr. should have a female chaperone during the consultation
7. Dr. should seek Comfort's permission to discuss her situation with other professionals	7. Dr. should make time to establish a rapport with Elaine and listen to her carefully	7. Dr. should adopt a sensitive and non-judgemental approach	7. Dr.'s approach should be open and non-judgemental
8. Dr. should discuss his concerns with Comfort and explain that he needs to make a referral to Social Services	8. Dr. should discuss treatment options, regarding her drug and alcohol problems, with Elaine	8. Dr. should not be complacent just because family are 'well-known' to the team	8. Dr. should listen carefully and judge slowly

9. Dr. should consider whether or not Comfort needs to be detained under a section of the Mental Health Act.	9. Dr. should be aware that asking questions about 'chastisement' is a potentially risky strategy and Elaine may walk out if challenged	9. Dr. should listen carefully and judge slowly	
10. Dr. should make time to establish a rapport with Comfort and listen to her carefully	10. Dr. should listen carefully and judge slowly		
11. Dr. should assess Comfort's mental capacity			
12. Dr. should assess the well-being of Comfort's children			
13. Dr. should 'seize the moment.' This opportunity to help the family may not arise again.			
14. Dr. Clarke should listen carefully and judge slowly.			

By the end of that day's surgery

Vignette 1 (Dr. Clarke)	**Vignette 2** (Dr. Amoah)	**Vignette 3** (Dr Imir)	**Vignette 4** (Dr Johnstone)
1. Dr. should identify appropriate interventions in response to Comfort's mental health problems	1. Dr. should refer to Social Services as a matter of urgency	n/a	1. Dr.should share relevant information with practice colleagues in case they are approached for information
2. Dr. should refer Comfort and her children to Social Services	2. Dr. needs to discuss this situation with the midwife		2. Dr. should help prepare the GP practice for the fallout that may follow, for example, requests, demands and complaints from other family members (seek medicolegal advice and have another colleague respond to family requests)
3. Dr. should obtain information about family and social support for Comfort and her children	3. Dr. should seek additional information from the Health Visitor		
4. Dr. should ask the Health Visitor to assess the home situation	4. Dr. should ask the Health Visitor to visit the family urgently to assess the children and the home environment		

5. Dr. should involve the Health Visitor on an on-going basis not merely on a one-off home assessment	5. Dr. must be very clear about agreed outcomes should he have an informal discussion with social worker		
6. Dr. should have an informal discussion with a senior social worker to talk around the problem rather than a straightforward referral	6. Dr. needs to manage this situation within an interagency framework		

By the end of the following day

Vignette 1 (Dr. Clarke)	**Vignette 2** (Dr. Amoah)	**Vignette 3** (Dr Imir)	**Vignette 4** (Dr Johnstone)
n/a	1. Dr. should provide information and advice regarding domestic violence, for example, information about Women's Aid refuges and an exit plan	1. If Dr. has concerns about the extent of parental learning disabilities he should contact the Learning Disabilities team for a proper assessment	1. Dr.needs to be clear what counselling is for and refer to appropriate services
	2. Dr. should draft an action plan in conjunction with other professionals		

Over a longer period

Vignette 1 (Dr. Clarke)	**Vignette 2** (Dr. Amoah)	**Vignette 3** (Dr Imir)	**Vignette 4** (Dr Johnstone)
1. Dr. should gain a broader picture and understanding of how Comfort is feeling and responding	n/a	1. Dr. should explain the need to liaise with teacher and school nurse to investigate Freya's situation further	N/A
		2. Dr. should consider the appropriateness and accessibility of practice resources in relation to disability	
		3. Dr. should arrange for the school nurse and dietician to assist the family	
		4. Dr. should seek the assistance of a patient advocate depending on the severity of Joanne's learning disability	

Appendix 13: Delphi findings: GP responses and timing in relation to vignettes

Not applicable

Vignette 1 (Dr. Clarke)	**Vignette 2** (Dr. Amoah)	**Vignette 3** (Dr Imir)	**Vignette 4** (Dr Johnstone)
1. In responding to Comfort's cultural needs Dr should not make assumptions and offer Comfort choice	n/a	1. Dr. should not assume that the wider family wish to be involved	n/a
2. The responses to some statements depend on those from others – each cannot be addressed in isolation			

Appendix 14: Delphi findings: Final Round 4 comments from the Panel in relation to the vignettes

Delphi panel members were invited to make comments at each stage of the process. These comments have been collated after round 4. The first number refers to the statement number (if attached to a specific statement). Letters in brackets identify the respondent (A..Y).

Vignette 1

3. GP should have an informal conversation with Social Care only if he/she is not sure what course of action to take. Depending on his/her initial assessment of the immediate safety and welfare of Comfort and her children, a formal referral should be made either as a child(ren) and family in need, or children in need of protection (A)

11. I don't think her consent is needed so response time doesn't apply (D)

12. GP should ensure there is HV input and that home visits are undertaken. This assessment should not be done in isolation of a multi-professional/ multi-agency approach (B)

15. Inaction would be inexcusable. The choice is about how to respond, not if and when (D)

How Dr Clarke deals with Comfort will depend on local service availability, which in turn will vary according to Dr Clarke's prior contact with services such as interpreters. Having prior relationships established with Social Work managers will be key to success (N)

Social services need to be alerted but a formal referral may not be made. I would refer to the emergency psychiatric team (O)

I am concerned that her cultural needs are not being addressed at all now (Q)

Vignette 2

2. The HV should not be undertaking an assessment in isolation, this needs to be part of a multi-professional/multi-agency response under agreed child protection procedures (B)

5. GPs should not be encouraged to have an informal discussion with Social Care, unless they are unsure what action to take! If so, there are training needs (B).

The wording here worries me – using chastisement in the same sentence as 'regularly giving a 2 yr old a 'good hiding', then suggesting the GP should consider the possibility of physical abuse is dangerous. Yes, the GP needs to know from the mother what is meant by the terms chastisement and good hiding but the Vignette describes the classic features of a child at serious risk, e.g. 2 yrs old, no protective adult (mother agrees with partners actions and values), child is seen as 'deliberately naughty'. Partner is new, possibly not the father of this child making them even more vulnerable, and is possibly inflicting domestic abuse on the child's mother who has injuries suggesting that she is unable to protect herself, not least a child (B).

This is a difficult case as the woman is disempowered with impaired autonomy so that one has to be proactive and paternalistic as the children are at real risk if there is domestic violence (60% risk of abuse and additional risk of PTSD from witnessing violence). ON the other hand if partner is aware of moves to protect family he could become more dangerous (4O).

Appendix 14: Delphi findings: Final Round 4 comments from the Panel in relation to the vignettes

Vignette 3

I think that in this vignette the important thing is to deal with the situation appropriately without losing the parents' trust insofar as possible. The pace of the response can be much slower than in the two previous scenarios and would probably benefit from being so (E).

Parents with LD tend to get stigmatised and pejorative assumptions made about their parental capacity (research evidence) (O).

Re 3 above – It would be interesting to ask if they should be treated differently to other parents just because of their learning disability as opposed to the presenting problem (Q).

Neglect is often neglected and is associated with very deleterious consequences (R).

Vignette 4

8. I'm still not convinced of the wording here 'prepare for the fallout' including demands from family etc. It is inflammatory language which gives a negative impression of what maybe expected as a result of 'doing the right thing' i.e. following agreed procedures. All practices should have protocols in place for dealing with complaints and requests for information, this should be treated in the same manner (B)

Dropping statement '3' is regrettable. This should be regarded as a priority requiring a quick response. I may be wrong but I'm concerned that the final draft could end up being inconsistent with the law [e.g. the Sexual Offences Act 2003] (D)

Many surgeries no longer keep urine pregnancy testing kits for other than exclusion of ectopic pregnancy. Local protocols may be to send Fiona to the local Hospital/Lab for blood testing, and therefore result may not be available until later that day. It may be that we need to argue with Government for Urine PT kits to be FP10/GP10 prescribable, but until they are, many GPs will be unable to comply with a "1" response time (N).

Waiting time for counselling may be in excess of 6 months, even for a child. No rush to start the process, except that artificially generated by the demands of "Choose & Book" (N)

I understand that, in certain parts of the UK, it is now the expectation that the Police and Doctors will notify sexual activity in anyone under 14: I think this is completely unacceptable, but demonstrates some of the conflicts between State and professionals (N)

Appendix 15: Delphi findings: To whom or where should GPs go to for professional advice in relation to conflicts of interests and safeguarding children?

In response to the question 'To whom or where should GP's go to for professional advice in relation to conflicts of interests and safeguarding children?' mean scores in relation to each item are presented indicating resources that GPs might draw on:

1: unimportant … 6: highly important

1. Named/designated professionals for safeguarding children	5.3
2. Experienced colleagues in the practice	5.2
3. Social Services	4.8
4. General Medical Council	4.7
5. Local paediatric experts/team	4.4
6. The advice of Senior Partner	4.3
7. GP procedures manual	4.2
8. RCGP's statements of principles	4.1
9. Health visitor	3.9
10. Legal frameworks e.g. Children's Act	3.9
11. Children services specialists	3.9
12. Medical Defence Union	3.9
13. Department of Health guidelines	3.8
14. Resources within the practice: mental health practitioners, nurses, OTs, other GPs etc	3.8
15. LCSB local guidelines	3.8
16. GP training information	3.5
17. British Medical Association	2.9
18. School nurse	2.9
19. Community child and adolescent mental health teams	2.9
20. Practice counsellor	2.9
21. Primary community mental health teams	2.8
22. Community paediatric teams	2.7
23. Charities and support groups e.g. ethnic minority support groups	2.6
24. Police	2.5
25. Drug and alcohol community teams	2.5
26. Crisis advisory service	2.5
27. Council services e.g. schools and nurseries	2.7
28. Older adult services	2.1
29. Citizen's advisory service	1.8

Appendix 15: Delphi findings: To whom or where should GPs go to for professional advice in relation to conflicts of interests and safeguarding children?

Round 2 findings (mean scores) in response to the question: To whom or where should GP's go to for professional advice in relation to conflicts of interests and safeguarding children *relating specifically to the 4 vignettes*. Sources are sorted by vignette and then ordered by rating of importance (descending).

1 = unimportant & 6 = highly important

Source	**Vignette**	**Rating**
Mental health services	1 – Comfort	5.2
Trans-cultural psychiatrist	1	3.4
Domestic abuse helpline	2 – Elaine	4.7
Midwife	2	4.6
Family key workers	3 – Joanne	4.6
Community health team	3	4.6
Dietician	3	3.8
Forensic medical examiner	4 – Fiona	4.4
Medico-legal services	4	3.9
Counselling services	4	3.6

Appendix 16: Additional Discussion in relation to vignettes

Fuller discussion of vignettes in relation to recommended timescales for GP's response

In round 4, the Panel members identified which GP ***response time*** for those statements reaching consensus they considered most appropriate as follows:

1 = By the end of this consultation
2 = By the end of that day's surgery
3 = By the end of the following day
4 = Over a longer period
5 = Not applicable

There was agreement in relation to **Vignette 1**, that by the end of the consultation, the GP should assess risk to, and the well-being of, the mother (Comfort) and her children, that he should inform Comfort of the limits of confidentiality (what information would be shared with whom, why and what would follow from this) and that records should be completed. Comfort's permission should, according to the Panel, be sought to discuss concerns with other professionals and the need to make a referral to social services would be explained to her. More specific responses included the need to assess Comfort's mental capacity and consideration of the need for detention under the Mental Health Act. Consensus statements also pointed to the need for professional judgement and an approach that enables the development of a rapport with Comfort. Responses over the longer term included the identification of appropriate interventions for Comfort's mental health problems, referral to social services and the involvement of the health visitor. An alternative to same-day referral also reached consensus: 'Dr Clarke should have an informal talk with a senior social worker to talk around the problem rather than a straightforward referral'.

Assessment, documentation and confidentiality were also evident in consensus statements in relation to **Vignette 2**. Within the consultation, the Panel view was that questions should be asked about 'chastisement' of the child and bruising on the mother (Elaine), that there should be consideration of the impact on the children of Elaine's drug problems and of the consequences of disclosing information in a potential domestic violence situation. Again, the need to discuss referral to social services was highlighted. Listening, judging slowly and the development of a rapport with Elaine were also consensus responses. Referral to social services by the end of the day was agreed and, again, the involvement of the health visitor supported. The Panel also agreed that the GP should also have a discussion with the midwife and that the situation should be managed within 'an interagency framework'.

Panel consensus statements suggested a less urgent response in relation to **Vignette 3.** The assessment of the child's (Freya's) general health and needs was recommended but also attention to the needs of the parents. The offer of treatment for the ear infection and health information relating to diet and head lice was considered important within the consultation as was the need to include Freya in discussion. A sensitive and non-judgemental approach was recommended, however, non-complacency was also

emphasised. In the longer term, Panel consensus supported the involvement of the Learning Disabilities team and engagement with the school nurse, dietician and the possibility of a patient advocate to support the mother 'depending on the severity of Joanne's [the mother's] learning disability'.

The Panel indicated that **Vignette 4** was the most serious and urgent of the four vignettes. Consensus statements regarding responses, within the consultation period, focused on the need to explain the limit of confidentiality to the child (Fiona), the need to obtain information about the 'sexual relationship', a pregnancy test, referral to social services and the assessment of mental capacity. The Panel consensus was also that the GP should have a female chaperone and his approach should be open and non-judgemental. As with the other vignettes, the significance of listening and professional judgement was considered important. By the end of the day, the Panel consensus was that the GP should share relevant information with practice colleagues and 'prepare the GP practice for the fallout that may follow', although as some respondents noted this phraseology may be unfortunate. It was also agreed, in the longer term, that the GP needs 'to be clear what counselling is for and refer to appropriate services.'

Statements not achieving consensus

A number of statements did not achieve consensus and these were removed (Appendix 11). In relation to **Vignette** 1, four statements were removed: three related to cultural needs, assessment and online translation and another to the decision to 'decide if the referral is for a child in need or a child in need of protection from significant harm. Five statements were removed from **Vignette 2:** two related to the GPs role in discussion of childcare options, another to a request that the mother should bring the children to the surgery the next day, another that the GP should see the children immediately and that he should speak to Children's Social Care while the mother is at the surgery.

Seven statements did not reach consensus in **Vignette 3**: the need for discussion with the Community Health Team with a view to completing a Common Assessment Framework (CAF), assessment of the mother's parenting capabilities and mental health, seeking permission to involve the wider family and arranging to see the mother at another time. The statement that the GP 'should view the problems presented as normal problems in children rather than as inadequate or poor parenting' was also removed (receiving 57% support). Panel responses in relation to **Vignette** 4 resulted in four statements being removed: the GP should encourage the child to confide in someone she trusts in the family; should offer counselling; should contact the police; and should arrange to see the child in a place where they can be observed.

Appendix 17: Themes relating to principles in relation to General Practice, conflicts of interest, and safeguarding children

This table presents themes identified in the analysis of principles that would guide a GP, grouped into five categories identified by the researchers. Columns 2 and 3 refer to the level of consensus achieved by Delphi panel members to the statements and the ranking of importance (after round 4), where 1 is least important and 10 is most important.

The Child Comes First	Agreement	Importance
30. The number one principle is the safety of the child	89%	10.00
1. The child's interests must be foremost – at all times all actions must be in the interest of the needs and safety of the child	94%	9.00
12. The cardinal principle is that the welfare of the child is paramount	94%	9.21
31. Where conflicts with the interests of adults arise, the welfare of the child is the over-riding consideration	89%	9.21
6. To do nothing if child abuse is suspected is not an option	94%	9.21
35. GP should not use *primum non nocere* (first do no harm) as an excuse for inaction	86%	8.29

Values for General Practice	Agreement	Importance
8. A GP must be honest at all times when dealing with these issues	94%	9.07
13. The GP should be prepared to admit mistakes	94%	9.07
11. GPs should always be transparent and uphold professional values	94%	9.14
14. GP should declare competing interests if appropriate	94%	8.43
15. GP should learn from difficult experiences relating to conflicts of interest	94%	8.79
7. Decisions must be based on evidence and analysis of the information gathered rather than assumptions	94%	8.57
25. GPs should adopt a holistic approach when making the assessment including practical, medical, psychological, social, cultural, moral and legal dimensions	89%	7.79
26. GPs must make a professional judgement as to the level of safety/health of a child	89%	8.07
37. GP should aim to do no harm, seeking the most therapeutic outcome	83%	7.86

Appendix 17: Themes relating to principles in relation to General Practice, conflicts of interest, and safeguarding children

Rules and Regulations	Agreement	Importance
5. Local procedures, professional guidance and law make it clear that the GP is under a duty to safeguard children and share information with appropriate agencies	94%	9.00
4. GPs must adhere to the legal framework, especially the Human Rights Act, the Convention on the Rights of the Child, and advice from the GMC on the Duties of a Doctor as all provide important principles	94%	8.93
19. GP's should always follow local sharing information protocols	93%	8.29
40. A GP has a statutory duty to take action when necessary to protect a child	78%	8.14
29. GPs should follow the principles set out in the Local Safeguarding Procedures	89%	8.43
38. GPs should used the named professional lead as the lynch pin, as he or she should be aware of all decisions made	78%	7.64
9. Always record, date and time all interactions with client, what concerns are, why and the course of action taken	94%	9.00
2. Communication is most important: if a GP ever feels unhappy with a decision that has been made, he or she should discuss it with parties involved	94%	8.21
20. GPs must trust colleagues who have expertise and not try to go it alone. Services are multi-professional for a reason	89%	8.71
21. GPs should train with other professionals and get in on the local networks	89%	8.57
16. GP should engage in a Significant Event Analysis	94%	8.07
32. If other agencies are mistaken, GPs should defend the interests of their patients	89%	7.50

Confidentiality	Agreement	Importance
23. Seek consent where possible but if this is not possible, or consent is withheld, ensure that only issues related to the protection of the child are disclosed	89%	8.79
22. The medical principle of patient confidentiality, including that owed to the child itself, may need to be overridden in order to safeguard the child	89%	8.50
27. A GPs professional judgement as to the level of safety/health of a child overrides any social circumstances that may arise from breaking confidentiality	89%	8.07
3. GPs should be sensitive to the effect of breaking confidentiality on an individual and make each individual aware of whom information has been shared with	94%	6.89

Appendix 17: Themes relating to principles in relation to General Practice, conflicts of interest, and safeguarding children

Caring for the Family	Agreement	Importance
36. GPs should be aware that all parties have interests and rights	83%	8.43
10. Seeing children as part of the family context, and helping and supporting parents may be the best way of safeguarding children	94%	8.36
18. GP should attempt to retain the trust of non-abusing relatives	94%	8.36
17. GP should aim to make all members of the family feel respected	94%	8.21
28. GPs have a duty to support vulnerable parents in their efforts to protect and nurture their children	89%	7.93
41. Seeing children as separate entities from the family, while sometimes essential, is not always so, and can do serious, long term damage	78%	7.86
33. GPs should use the therapeutic relationship as much as possible to help resolve issues	89%	7.64
34. GPs must take into account the autonomous wishes of the individual and other peoples' needs/ desires in outcome of problem	86%	7.14
24. Respect different cultures and understand their belief systems	89%	7.71
39. Conflict may be more apparent than real	78%	6.86

Appendix 18: Details of participants of Delphi panel who wished to be acknowledged

We wish to express our gratitude to members of the Delphi Expert Panel for their generosity in sharing their experience and expertise and for their patience and perseverance. Some members of the Panel preferred to remain anonymous. Other members of the Panel are as follows:

Martin Blakebrough – Chief Executive Officer
Andrew Cooper – Professor of Social Work and Director of R & D
Fiona Fontaine – Health Visitor
Danya Glaser – Consultant Child and Adolescent Psychiatrist
Paul Grob – Professor and General Practitioner
Ian Higgins – Nurse Consultant, Honorary Lecturer
Deborah Kitson – Director, Ann Craft Trust – ACTing against Abuse
Betty Lynch – safeguarding children & Harrow Local Safeguarding Children Board, in collaboration *with*
Dr Genevieve Small – GP & named doctor for safeguarding children
Sophie Meldon – Multi-Agency Team Coordinator
Pat Monro – Solicitor & Immigration Judge (Part-time)
Andrew Mowat – Safeguarding Children Lead, East Lindsey Practice-Based Commissioning Group, Child Health Lead, Royal College of General Practitioners
Eileen Munro – Reader in Social Policy
Marian McGowan – Consultant Paediatrician
Mayvis Oddoye – Senior Nurse, mental health (Lead, Safeguarding Children)
Jan Vince – TLR for vulnerable children, Teacher in Charge of Speech, Language & Communication Needs Centre, and Child Protection Liaison Officer
Roger Worthington – Lecturer in Healthcare Law and Ethics, University of Keele
Dr Paquita de Zulueta – General Practitioner, Honorary Senior Lecturer

We also wish to thank Dr Catherine Powell for her advice in the early stages of the Delphi Process.

Appendix 19: Developing a model for training purposes: understanding GPs' roles in safeguarding children

Developing a Model for Training Purposes Understanding GPs' roles in safeguarding children

1. Introduction

Drawing on this research study, a model to represent the issues raised from the data about the expectations and perceptions of GPs' roles is emerging, and is to be presented at a seminar for GPs who are specialists in this field. It is hoped to identify ways of resolving discrepancies between expectations and perceptions from GPs (Fig. 1) and other professional perspectives (Fig. 2) using the model. This model also makes connections with "The Common Assessment Framework as part of a continuum", Working Together, 2006 and the National Service Framework, 2004[1].

2. Axes for the model

Axis 1. Continuum of Safeguarding and Promoting the Welfare of Children and Child Protection

Promotion of child(ren)'s development and wellbeing (universal)	**Acting proactively for risk prevention/ reduction (targetted)**	**Identifying parental hazards**	**Recognizing actual neglect or harm**	**Protection from harm/further harm**	**Rescue or recovery (damage limitation)**
e.g. safe births, developmental health checks, Early Years/ e.g. nurseries, Schools/ Education. National Service Framework Health promotion, immunization (childhood and teenage). School dinners	Identifying vulnerable children -targetted help for children with special needs, e.g. disability, SEN, mental health. Surestart, Obesity clinics, Breakfast/After School Clubs.	Identifying vulnerable parents (e.g. drug or alcohol dependance), Domestic violence, Mental Illness or severe Learning disability (and especially with other social factors, e.g. financial difficulties, single/young parent) Professional involvement factors.	Failure to thrive, Bruising, Relationship or behaviour difficulties	Multi-professional information-sharing, Case conferences, Identifing child in need or at risk (secs. 17/47) Integrated children's care plans (child protection register), Investigation of criminal proceedings	Legal proceedings to take parental responsibility, Children to become "looked after", Provision of alternative care, Follow-through care plan

[1] www.everychildmatters.gov.uk/resources-and-practice/search/G00062 Accessed 24.10.07

Axis 2. Degree of Professional involvement/concern

Low	Moderate	High
Examples of activity: Supportive Responsive to self-referral Referrer on Gateway to other services Overall passive monitoring	*Examples of activity: Targetted support Active monitoring*	*Examples of activity: Proactive Intervention High level of support*

3. Points to make through the model

a) GPs expect to be consistent, supporting parents and, through them, families, referring on for help and advice from others , receiving feedback and acting as conduit for services and information, a "gateway" and assembler of the "jigsaw".

b) Other professionals expect GPs to be very aware, vigilant of parental difficulties, and engaged with child welfare/protection systems (e.g. attending case conferences, provide reports) and sometimes feel GPs are not fully engaged with the other protective services or processes.

c) GPs see social services as often responding too fast or not at all, and usually not providing feedback to a referral. GPs tend to use other health professionals as a conduit to social services/children's care services.

d) Health visitors used to see all children under 5 but may not do this now, but are still a main conduit for referral/discussing concerns.

e) School nurses are difficult to access, but usually refer on to social services very quickly.

f) Named professionals (doctor/nurse) give advice (but GPs remain responsible) and are usually seen as trusted health colleagues.

g) Paediatricians/community paediatricians are often the favoured choice of advice/referral, and may take over responsibility to refer on if needed.

h) Lead professionals/coordinator for children with needs: not always known to GPs.

4. Important issues affecting perceptions/expectations

a) The aim of government policy seeks to bring recognition and intervention earlier in the safeguarding process, in order to reduce the likelihood of child removal/family breakdown.

b) Social services want GPs, Named and other Professionals to work with them on strategic reviews, initial assessments, CAF, and child protection plans.

c) GPs and their practices are described together in the guidance (Working Together, 2006), and have shared responsibilities, but GPs make their own decisions as individual practitioners.

d) The opportunities for discussion available to GPs appear to be later than they would prefer, i.e. at an earlier stage with trusted individuals, either hypothetical or specific, and where it is still resolvable and under the GP's control.

5. Possible limitations of the model

a) It may look linear and as if situations only and always get worse – early support and professional intervention can benefit family situations and they do improve;

incorporating a spiral dimension demonstrating potential resolution of problems may need to be more explicit.

b) A time line is not included – this may be a 3rd dimension to the model.

c) The age of the child is not addressed, but would be significant in relation to pre-school/school age provision/oversight.

d) It is difficult to present the impact of professional intervention which can in itself put pressure on parents and create a new form of parental hazard (e.g. resistance to support, blame to children for interference in the family).

e) Does the model pay enough attention to children and rather more to parents?

f) Are children with disability or complex needs overlooked in the focus on children at risk of significant harm?

g) It is difficult to represent different responses depending on the individual case, e.g. GPs may have no problem sharing information or concerns when there is an urgent and serious situation, where they may have more difficult in uncertain situations or where there is unproven neglect.

h) Identification of "professional involvement" as an axis may not reflect fully enough the range of expertise, experience, concern, relative responsibility that exists for individual professionals and may suggest or imply levels of risk in individual cases.

6. Possible strengths of the model

a) It may illustrate more clearly the specific points where GPs find difficulty with processes/protocols and balancing their ethical dilemmas with others' expectations.

b) It could build on the understanding of the CAF/prevention-protection continuum to include more fully the preventive and universal aspects of care that can be more commonly the domain of GPs, health visitors, and schools, rather than the critical aspects of child protection which can be traditionally seen as predominantly the domain social services are involved with.

c) The identification of vulnerable children *and* vulnerable parents may more readily link with the GP perspective which takes account of every patient's needs in the family.

d) The consideration of parental involvement in the model may reflect more strongly the GP's focus on supporting families through parents.

e) It could help GPs to identify where they need to initiate new discussion zones or what kind of training (multi or health-professional) would improve confidence and trust in referral to and responses from other professionals.

Figure 1. Some GPs' Perceptions of Existing Practice

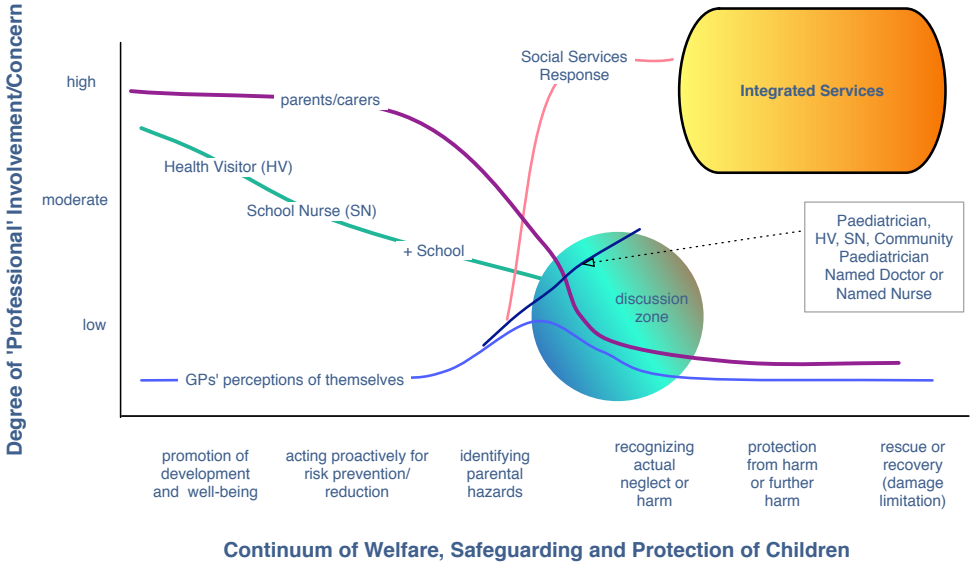

Figure 2. Others' Expectations of GPs Existing Roles