



DfES/DH Research Project

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

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CONTENTS

ACKNOWLEDGEMENTS	III
GLOSSARY	V
LIST OF TABLES	VII
EXECUTIVE SUMMARY (SEE SEPARATE DOCUMENT)	
SECTION 1: INTRODUCTION TO THE PROJECT AND THE CONTEXT OF THE RESEARCH	1
1.1 BACKGROUND TO THE PROJECT	1
1.2 CONTEXT OF THE RESEARCH – A CHANGING ENVIRONMENT	1
1.3 POLICIES AND FRAMEWORKS TO SAFEGUARD CHILDREN	3
1.4 PROFESSIONAL GUIDANCE AND CONFLICTS OF INTEREST FOR GPs IN SAFEGUARDING CHILDREN	6
1.5 LEARNING FROM THE PAST	11
1.6 THE GP CONTRACT	12
1.7 EXPECTATIONS OF THE GP ROLE IN SAFEGUARDING CHILDREN	15
SECTION 2: THE LITERATURE REVIEW	17
2.1 INTRODUCTION	17
2.2 CHILD ABUSE AND NEGLECT	17
2.3 THE CENTRAL ROLE OF THE GP?	19
2.4 THE GP MODEL OF PRACTICE	21
2.5 THE FAMILY FOCUS	22
2.6 THE GP ROLE WITH CHILDREN WITH DISABILITIES	24
2.7 THE GP ROLE WITH CHILDREN FROM ETHNIC MINORITIES	25
2.8 THE CHILD PROTECTION PROCESS	26
2.9 THE PRIMARY HEALTH CARE TEAM	28
2.10 INTER-AGENCY WORKING	28
2.11 CONFIDENTIALITY AND THE SHARING OF INFORMATION	29

2.12	TRAINING IN CHILD PROTECTION	30
2.13	CONCLUSION	32
	SECTION 3: AIMS AND OBJECTIVES	34
3.1	AIMS AND OBJECTIVES	34
3.2	DISSEMINATION OF FINDINGS	35
3.3	ETHICAL APPROVAL AND GOVERNANCE	36
3.4	PROJECT MANAGEMENT	36
	SECTION 4: METHODOLOGY, METHODS, AND SAMPLES	38
4.1	METHODOLOGY AND METHODS	38
4.2	THE PRIMARY CARE TRUSTS IN THE STUDY	38
4.3	PURPOSES OF THE STUDY METHODS	40
4.4	COMMENTS ON THE SAMPLING PROCESS	42
4.5	METHODS OF ANALYSIS	46
	SECTION 5: FINDINGS ACROSS THE METHODS IN THE STUDY	49
5.1	ANALYSIS OF GP QUESTIONNAIRES	49
5.2	ANALYSIS OF GP INTERVIEWS	63
5.3	ANALYSIS OF KEY STAKEHOLDER INTERVIEWS	79
5.4	ANALYSIS OF FOCUS GROUPS	96
5.5	ANALYSIS OF DELPHI FINDINGS	109
	SECTION 6: DISCUSSION OF FINDINGS ACROSS THE METHODS IN THE STUDY	115
6.1	INTRODUCTION TO DISCUSSION	115
6.2	INTERESTS, CONFLICTS, AND FREQUENCY OF CASES AND DILEMMAS FOR GPs	116
6.3	THE DOCTOR/PATIENT RELATIONSHIP	119
6.4	THE ROLE AND EXPECTATIONS OF THE GP IN SAFEGUARDING CHILDREN	122
6.5	DECISION MAKING IN THE SAFEGUARDING PROCESS AND PARTNERSHIP	130
6.6	THE GP RELATIONSHIP WITH OTHER CHILDREN'S SERVICES	136
6.7	INFORMATION SHARING, CONFIDENTIALITY AND CONSENT	141

6.8	THE FRAMEWORK FOR PROVIDING GP SERVICES	143
6.9	FORGOTTEN OR INVISIBLE CHILDREN?	145
6.10	BEST PRACTICES FOR MANAGING TENSIONS AND CONFLICTS	148
6.11	LIMITATIONS AND STRENGTHS OF THE STUDY	151
	SECTION 7: SUMMARY OF STUDY AND IMPLICATIONS FOR PRACTICE AND POLICY	153
7.1	CONTEXT AND SUMMARY OF STUDY	153
7.2	SUMMARY OF KEY FINDINGS	155
7.3	COMPARING PERSPECTIVES: GPs AND OTHER PROFESSIONALS – KEY MESSAGES FOR POLICY AND PRACTICE	156
7.4	AREAS IDENTIFIED FOR FURTHER RESEARCH AND KEY RESEARCH MESSAGES	161
7.5	CONCLUDING COMMENTS	163
	SECTION 8: BIBLIOGRAPHY	164
	SECTION 9: LIST OF APPENDICES IN DOCUMENT 2	176
	METHODS ANNEXES:	177
1	THE DELPHI METHODOLOGY	177
2	DETAILS OF STATISTICAL TESTS	182
3	ANALYSIS OF FINAL THEMES EMERGING ACROSS THE STUDY METHODS	184

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The views expressed in this report are those of the authors and not necessarily shared by the DOH/DCSF

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GLOSSARY OF ABBREVIATIONS AND TERMS USED

ACPC	Area Child Protection Committee – now subsumed within LSCBs on a statutory basis.
BMA	British Medical Association
BME	Black and Minority Ethnic Groups
Children's Services	Following structural changes in response to the Children Act 2004, from 2006 education and social care services for children have been brought together into Children's services: Many professionals and the public still refer to Children's Services as social services – the term children's social services is used in this document for this reason.
CAF	Common Assessment Framework for all agencies (ECM 2003)
Contact-Point	Previously known as the Information Sharing Index, this is the name of the proposed national database for children under the Information, Referral and Tracking initiative: http://www.everychildmatters.gov.uk/deliveringservices/contactpoint .
DfEE	Department for Education and Employment
DfCSF	Department for Children, Schools and Families - from 2007
DfES	Department for Education and Skills - <i>until 2007</i>
DOH	Department of Health
Designated Doctor	Senior Doctor (Paediatrician) taking a strategic professional lead on all aspects of health service contribution to safeguarding children in the PCT
Designated Nurse	Senior Nurse taking a strategic professional lead on all aspects of Health service contribution to safeguarding children across the PCT
Fraser competent/ guidelines	Fraser competence refers to guidelines (developed under Lord Fraser as one of the Lords involved in the Gillick judgement in 1985) concerned only with contraception - whether a minor has the capacity to consent to medical treatment and their rights to confidentiality and the non-involvement of those with parental responsibility.
GMC	General Medical Council

General Practitioner GP	Medically qualified doctor holding RCGP certificate who practices general medicine as family practitioner based in the community. Some GPs have additional qualifications and specialist interests.
Gillick competent	Gillick competence is a term used in medical law since 1983/5 to describe when a minor (under 16) may be able/has the capacity to consent to his or her own medical treatment, despite a young age. See Fraser competent, above. These two terms are often used interchangeably but have quite different meanings.
HMG	HM Government
ICS	Integrated Children's System. Replaces the Child Protection Register (see http://www.everychildmatters.gov.uk/socialcare/integratedchildrensystem).
LSCB	Local Safeguarding Children Boards. Replaced Area Child Protection Committees and have a wider remit for safeguarding children.
Named Doctor and/or Named Nurse	Doctor or nurse within PCT taking a professional lead within the PCT for safeguarding children.
PCT	Primary Care Trust
QOF	Quality and Outcomes Framework - measures performance of GP practices as part of General Medical Services GP Contract.
RCGP	Royal College of General Practitioners
RCPCH	Royal College of Paediatrics and Child Health
RCP	Royal College of Physicians
SC PCT	Shire County PCT area
SL PCT	South London PCT area
Trafficked children	Children brought into the country illegally for purposes of exploitation.

List of Tables

1	CROSS-REFERENCE BETWEEN RESEARCH QUESTIONS AND RESEARCH METHODS	39
2	DEMOGRAPHIC DATA FOR THE SAMPLE PCTs	40
3	GP QUESTIONNAIRE RETURNS	43
4	COMPLETED QUESTIONNAIRES AND GENDER OF RESPONDENTS	50
5	ETHNICITY OF GPs	50
6	YEARS OF EXPERIENCE AS A GP	50
7	SIZE OF GP PRACTICE: NUMBER OF GPs IN EACH PRACTICE	50
8	LEVEL OF GP CONCERN ABOUT EFFECT OF PARENTAL DIFFICULTIES ON SAFETY OF CHILD	52
9	LEVEL OF CONCERN ABOUT CHILD PRESENTATION	54
10	GP PARTICIPATION IN CHILD PROTECTION TRAINING SINCE 2003	55
11	RANGE OF PROFESSIONALS THAT GPs MAY CONSULT WHEN FACED WITH CHILD PROTECTION CONCERNS	56
12	EFFECTIVENESS OF CHILD PROTECTION PROCEDURES	57
13	GP INVOLVEMENT IN CHILD PROTECTION CASE CONFERENCES	59
14	INFORMATION SHARING AND CONFIDENTIALITY	60
15	COMPLETED INTERVIEWS, ETHNICITY AND GENDER OF RESPONDENTS	63
16	YEARS OF EXPERIENCE AS A GP	63
17	SIZE OF GP PRACTICE: NUMBER OF GPs IN EACH PRACTICE	64
18	SPECIAL INTERESTS OF GPs	64
19	DELPHI PANEL: EXPECTED ALLOCATION OF ACTIONS/STATEMENTS TO TIME PERIODS BY GPs	113
20	THE DIFFERENT ROLES OF GPs IN SAFEGUARDING CHILDREN	124

SECTION 1: INTRODUCTION TO THE PROJECT AND THE CONTEXT OF THE RESEARCH

1.1 BACKGROUND TO THE PROJECT

This project was one of nine funded by the Department for Education and Skills (DfES)¹ and Department of Health (DH) as part of the Safeguarding Children Research Initiative 2005. The projects were grouped under three themes:

Theme One: Recognition of neglect or emotional abuse

Theme Two: Impact of interventions on outcomes for children

Theme Three: Inter-agency working.

The research into tensions and conflicts of interest for General Practitioners (GPs) in safeguarding children was one of the inter-agency working projects, and will be contributing to the other themes with its focus on the significance of the GP in identifying and responding to child protection concerns.

This section sets out the context for this research and the policies and frameworks in place to safeguard children in England and Wales. A review of professional guidance for GPs and the potential conflicts of interest is followed by consideration of learning from the past, the General Medical Services Contract 2003 (the GP contract, BMA 2003) and expectations of the GP role in safeguarding children.

1.2 CONTEXT OF THE RESEARCH – A CHANGING ENVIRONMENT

This project started in May 2006 and within its two year duration noted significant changes in language, systems, structures and policies. These continued to evolve with geographical and timeframe variation, e.g. the demise of Area Child Protection Committees with the establishment of Local Safeguarding Children Boards (LSCBs), the relocation of key professionals involved with children such as health visitors in

¹ Department for Education and Skills (DfES) has now been replaced by Department for Children, Schools and Families (DCSF); this report has retained the title DfES in keeping with the origin of the project.

Children's Centres, and the division of social care services and workforce organizations into Adults and Children's Services.

Many of the participants in this study continued to refer to social services as opposed to Children's Services and use the term 'child protection' as opposed to 'safeguarding children'. The term 'children's social care services' has been used in this study to bring it up to date, but the terms 'safeguarding' and 'child protection' are used interchangeably in this study, reflecting usage by participants. *Working Together to Safeguard Children*² (HMG 2006a) defines safeguarding and promoting welfare to enable children to have "*optimum life chances and enter adulthood successfully*", to include:

- *protecting children from maltreatment,*
- *preventing impairment of children's health and development,*
- *ensuring that children are growing up in circumstances consistent with the provision of safe and effective care (ibid. 1.18)*

A separate definition of child protection describes it as "*activity... (as)... part of safeguarding and promoting welfare...to protect children who are suffering, or at risk of suffering significant harm*" (ibid. 1.20). This research has raised questions as to whether a focus on the term 'safeguarding' has succeeded in emphasizing the more general needs of all children, or whether in practice, activity continues to be focussed on the more critical end of child welfare in line with limited resources, priorities and measurable targets.

Systems under development such as those for the recording of data on children in need of protection and the proposed child index also changed during the course of the project along with other policy updates. The study has attempted to present information as it was during its time span, and as up to date as possible, recognizing the fast pace of change and the necessary transitions in the implementation of new government initiatives.

² Full title: *Working Together to Safeguard Children: a guide to Inter-agency Working to Safeguard and Promote the Welfare of Children (2nd edition)*

1.3 POLICIES AND FRAMEWORKS TO SAFEGUARD CHILDREN

Guidance on safeguarding children ranges from government guidance targeted at all professionals involved to profession specific advice from regulating bodies, professional associations and other agencies. Reports and enquiries following child deaths have made recommendations for change and have indeed influenced change. *The Laming enquiry into the death of Victoria Climbié* (Laming 2003) made a series of recommendations to improve practice both within and between agencies involved in safeguarding children. A key message was the importance of not only sharing information, but also being able to piece this together in order to understand its significance and enable a holistic assessment and appropriate interventions to take place. Recommendations directed towards both paediatricians and GPs covered how information should be recorded and shared; those directed specifically to GPs covered how new child patients should be registered, and training in child protection and knowledge of local policies and procedures (NHS Confederation 2003, p. 5).

The government was quick to respond to the Laming enquiry in the document *Keeping Children Safe*³ (DH & DfES 2003), and subsequent guidance in *What to do if You're Worried a Child is being Abused* (DH 2003, HMG 2006b), and the Children Act 2004 was driven by the findings and recommendations of the report.

The publication of *Every Child Matters*⁴ (DfES 2003) and the associated Change for Children Programme (HMG 2004) reinforced the policy of integrated services and joint working by a cross section of professionals, to provide an inclusive service to all children. This policy stressed, among other things, (a) early detection and intervention and the provision of suitable support services for children and their families, (b) workforce reform and training, and (c) integrated services and joint working by a cross section of professionals. It was also hoped that the identification of disabilities and disadvantage early in childhood would promote the provision of inclusive services for all children, including those with special needs and disabilities.

³ Full title: *Keeping Children Safe: the government's response to the Victoria Climbié Inquiry Report and Joint Chief Inspectors' report Safeguarding Children*

⁴ Full title: *Every Child Matters: Green paper on child services*

The second edition of *Working together to Safeguard Children* (DH, HO & DfEE 2006) brought the earlier guidance from 1999 into line with the new policies concerning the responsibility of all professionals to disclose information where there was suspected harm or risk to a child. This, together with *What to do if You're Worried a Child is Being Abused* (DH 2003, HMG 2006b) outlined guidance and processes to all professionals working with children including definitions of abuse and neglect, roles, responsibilities, and requirements for action/involvement at all stages of the processes of safeguarding children. The majority of references to GPs' responsibilities were amalgamated under "*the general practitioner, the primary health care team, practice employed staff and school nurses*" (2.74-2.83). The first three of these groups were seen as having key roles in identification of vulnerable children, those who have been abused and those at risk, and in subsequent intervention. Clarification of the legal restrictions on information sharing, as provided in Appendix 3 of the document (Common Law duty of confidence, Human Rights Act 1998, Data Protection Act 1998), as well as guidance on confidentiality and consent, sought to address potential areas of dilemmas for professionals.

Later government policies and legislation designed to promote the welfare of children and safeguard them from harm were based on the assumption that services are best provided by inter-agency collaboration. The introduction of the *Framework for Assessment of Children in Need and their Families* (DH 2000b) and the associated practitioners' guide (HMG 2006a), to be used with all agencies and disciplines working with children, together with the *National Service Framework for Children, Young People and Maternity Services* (DH 2004) has promoted and developed inter-agency working⁵. The Children Act 2004 focused on the integration of services, with an emphasis on shared outcomes for children across services - "*being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well being*" – from *Every Child Matters*⁶ (DfES 2003). Integrated services includes:

⁵ The Common Assessment Framework introduced in 2006 for all professionals was still at the trailblazer stage during this project (HMG 2008).

⁶ Full title: *Every Child Matters: Green paper on child services*

the requirement for broad local partnerships of relevant agencies to work together to improve the well-being and protection of children in the area; the establishment of multi-agency Local Safeguarding Children Boards (LSCBs); the development of local Children's Trusts, and the establishment of information sharing systems (Children Act 2004, s12).

It is clear that early detection relies on clear information sharing and sharing of responsibility; workforce reform promotes the need for professionals to be equipped with an ability to assess factors affecting children's wellbeing and threats to this, which are sensitive to the contexts that children and parents/carers find themselves in; and finally, successful integration of services and joint working relies on shared understandings of each other's roles, contribution and the constraints under which different professionals operate. As part of this shift from protection to prevention and the promotion of better outcomes for all children, child protection registers were to be replaced in April 2008 with the Integrated Children's System where for children at risk there would be more emphasis on a child protection plan.

Many countries, but not the UK, have mandatory reporting as the basis of their child protection system. The Information, Referral and Tracking initiative (known as the Information Sharing Index (HMG 2006b), renamed 'ContactPoint' – HMG 2008) was originally intended to require professionals including GPs to flag up 'a cause for concern for a child's welfare' on a national data base for children.⁷ This could be seen as the beginnings of mandatory reporting in England (Munro & Parton 2007). The advice on confidentiality is that, while there is currently no mandatory requirement to report or disclose concerns, the law and professional guidance permit disclosure, where necessary, to protect a child against risk of harm (GMC 2004, BMA 2004). There is a tension between sharing information and the rules governing confidentiality, and this may give rise to conflicts of interest for the GPs in decision making at the referral stage. If GPs believe that they have concerns about a child's

⁷ From 2009 the database will include as standard informational data only, on the child, parent or carer, any services working with the child, and whether the practitioner is a "lead professional" and/or has undertaken an assessment under the Common Assessment Framework (CAF) (HMG 2006a)

welfare, they should always refer to the local authorities children's social care and may lawfully share information, if the child consents, or there is a public interest or a clear risk of significant harm and the information sharing is proportionate (HMG 2006c, p 104-5). Section 2.76 (ibid.), however makes clear that 'appropriate information sharing' is "*subject to normal confidentiality requirements (and) relevant information*" – all of which imply the use of professional judgement. In cases that are being investigated under s47 enquiries under the Children Act 1989, GPs have a statutory duty, as do all health services, to 'help' local authorities in carrying out their social services functions to ascertain whether a child is "*suffering, or is likely to suffer from, significant harm*", even if such 'help' is not defined.

It is suggested that future regulations are likely to justify sharing of information, and the overriding of consent, whenever there are concerns for child protection (Munro & Parton 2007). However, Bell & Tooman (1994) and Ward et al. (2004) have already noted that mandatory reporting may prove problematic and this could well be the case for GPs.

1.4 PROFESSIONAL GUIDANCE AND CONFLICTS OF INTEREST FOR GPs IN SAFEGUARDING CHILDREN

There is a wealth of profession specific advice to draw on. GPs have a duty to act in the best possible interests of the patient in front of them (GMC 2006). However, the Royal College of Paediatrics and Child Health published *Responsibilities of Doctors in Child Protection Cases with Regard to Confidentiality* (RCPCH 2004) affirming:

- the 'paramourncy' principle of the child's best interests and needs, "*if there is conflict between doctor and parents or parents and child*" (no. 1 p. 9)
- the good practice approach to gaining consent where possible to disclosure of information or reporting of concerns to other professionals
- the justification of prioritizing protection before seeking parental consent to disclosure where there are 'overwhelming reasons' or risk to the child, a sibling, the parent (risk of suicide), the doctor (risk of violence), or to any evidence ("*where the information would help prevent, detect or prosecute a serious crime*")

- the separation of the parent and child from consideration as a single unit ('the patient'), where there is a conflict of interests, or suggestions, signs or symptoms of abuse.

This document refers also to the substantial GMC guidance on confidentiality (1998, 2000, 2001, and 2004). Guidance on responses to indications of physical and sexual abuse appears to be clearer than where there are suspicions of emotional neglect and abuse, which may appear more subjective or less easily defined. The case study investigation in the South West region of England into the contribution of the NHS in child protection found that, while GPs "*accepted ethical and legal principles of disclosure, it was the less overt concerns or suspicions that caused them conflict or doubt*" (Lupton et al. 2001, cited in Morgan 2002, p 11).

Advice to paediatricians is that their primary duty is to the child, while adult psychiatrists owe a duty primarily to the parent, but GPs may have both child and parents/carers as their patients. The case of Daksha Emerson (Joyce et al. 2003), a doctor who killed herself and her child while suffering from depression, highlighted the dilemmas of identifying risk and knowing when to breach confidentiality. GMC's guidance on confidentiality (GMC 2004) offers guidance on where explicit consent is required for disclosure of information and separates out 'public interest' from a child or patient's best interests. The RCPCH (2004) recommends that the GP should always seek consent to share information unless this will place the child at further risk, and where consent is withheld, the GP will need to decide and justify whether disclosure is a proportionate response to the need to protect a child.

BMA Guidance on *Doctor's Responsibilities in Child Protection Cases*⁸ (BMA 2004) confirms that "*the doctor's chief responsibility is to the well being of the child or children concerned, therefore when a child is at risk of serious harm, the interests of the child override those of parents and carers*" (p 1). However the guidance recognizes the "*difficult and demanding*" aspects of working with children and families where there are concerns about neglect or abuse, and acknowledges areas of

⁸ Full title: *Doctors' Responsibilities in Child Protection Cases: Guidance from the Ethics Department*

potential conflict, such as when children do not want information disclosed about them, how to discuss actions to take without breaching patient confidentiality, and where the rights of children under the UN Convention on the Rights of the Child 1989 may be in tension with the rights of children and parents under the Human Rights Act 1998.

The GMC attempted to address this in *0 -18 years: Guidance for all Doctors* (2007) by stating that children and young people are “*individuals with rights that should be respected*” (point 5) and offering guidance as to how doctors must safeguard and protect the health and well being of children and young people. The GP relationship with the parents of older children may be in conflict, where a young person’s wishes about medical care do not concur with those of their parents or where they do not wish information to be shared with them. The GP will need to determine Gillick competence (see Glossary) of a young person and also consider the impact on the young person if they breach their trust.

Where there are cultural issues in cases that may make decisions difficult, the BMA states that all GPs should be trained in cultural sensitivity and apply this in their practice. It also offers guidance on specific issues such as female genital mutilation and child protection (BMA 2006). The guidance clearly states that the child’s needs are paramount and take precedence over cultural issues. The DH and DfES (2003) *Keeping Children Safe* emphasized the importance of training for GPs around issues of culture.

BMA Guidance recommends confidential information should not be divulged without consent (p 4) and discussion towards ‘voluntary disclosure’. For young children, where parents/carers would normally be involved in decisions about them, parents or carers would be consulted, unless “*there is a reasonably found belief that it would put the child at further risk of harm*”. Patients’ implied consent to sharing information within Primary Care Trusts (PCTs) is seen as relatively less contestable. The Medical Defence Union advice (Hoyte 1998), however, recommended a more cautious approach to the divulging of information, and continues to do so (Roberts 2007) in an increasingly litigious clinical/professional context.

Emphasis in the BMA Ethics Guidance reflects the dilemmas facing GPs in decision making and advises consultation “*with other colleagues and health care professionals*”, adding also that advice may be sought from “*trained professionals with experience in child protection*” (BMA 2004, p. 4). Hypothetical, ‘no name’ case discussions are suggested as helpful ways to resolve decision dilemmas, rather than contacting other professionals to share information about specific families with a view to checking perceptions. The decision as to whether there is justified cause for concern is seen as the first stage of decision making, rather than the decision to report or refer on.

In addition to specific guidance on ethics, confidentiality and child protection, general guidance provided by the GMC in 2006, under the heading of *Good Medical Practice: Duties of a doctor registered with the General Medical Council*, outlines professional behaviour expected towards patients to earn trust. These include treating patients as individuals, being honest and open, and working with colleagues to serve patients’ interests best. It reminds doctors that that they must... “*never abuse...patients’ trust in (them) or the public’s trust in the profession*”. Many of the values and principles that inform medical practice are contained in the Royal College of Physicians’ (RCP) report *Doctors in Society*⁹ (2005) which set out the College's view of medical professionalism:

“Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors” (p 57).

Professionalism in medicine is defined in the RCP report as:

“a vocation in which a doctor’s knowledge, clinical skills, and judgment are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability” (p 26).

⁹ Full title: *Doctors in Society: Medical professionalism in a changing world: Main report*

In terms of the values inherent in medical practice the report identifies that in their day-to-day practice, doctors are committed to:

- integrity
- compassion
- altruism
- continuous improvement
- excellence
- working in partnership with members of the wider health care team

References to ‘partnership’ and ‘team’ here do not specifically identify the wider professional partnerships inherent in safeguarding children requirements – as in *Working Together to Safeguard Children* (DH 1999, 2006) – and may present GPs with apparently different requirements of perspective, communication and behaviour.

The RCGP (2007) notes that the ‘patient principle’ requires that doctors place the needs of patients before their own interests. The potential complexity of these conflicts “*can introduce an adversarial or confrontational element into an area that has traditionally focussed on consensual care*”. Decisions facing doctors in complex circumstances may be in relation to treatment decisions, where health or development is at risk, or a potential incidence of abuse or neglect, which might need referral to other agencies under *Working Together to Safeguard Children*/LSCB guidelines.

The values, which underpin the science and practice of medicine, form the basis for a moral contract between the medical profession and society, and for the professional expectations of GPs by patients, which will be of relevance to the discussions in this study, when GPs are dealing with judgements/ethical dilemmas concerning children’s welfare. The RCGP recognises that while GPs remain the first point of contact for most child health problems, child protection traditionally “*enjoys the non-engagement of GPs*” (Birchall & Hallett 1995, Carter & Bannon 2002; Hendry 2003), and issued the *Keep me Safe*¹⁰ strategy for Child Protection (RCGP 2005). This document examined “*child protection as it relates to general practice in the current policy and*

¹⁰ Full title: ‘*Keep me Safe*’ *The RCGP strategy for Child Protection*

research context” with reference to the Climbié Inquiry and led to the development of the RCGP Tool Kit in collaboration with the NSPCC (RCGP 2007). This had the specific aim of increasing the awareness and skills of GPs regarding Child Protection to “*promote a change in the behaviour of doctors and enhance the ability of primary care teams to support young patients at risk*”.

1.5 LEARNING FROM THE PAST

The *Inquiry into the death of Maria Colwell*¹¹ (DHSS 1974) marked the emergence of the modern era of working together in British child welfare (Hudson 2005), with a significant growth in legislation, policy and procedures to support the protection of children. A key expectation was that this would lead to closer collaboration between professionals and reduce the chances of further failures in the system. Reder and Duncan (2004) recorded that since that time there were around 40 fatal child abuse enquiries and serious case reviews and that while child deaths remain rare, the same themes continue to emerge. These centre on inter-agency coordination and information sharing, assessment and decision making skills, resources in terms of staff levels and expertise, and compliance with policy directives and procedures.

Key aspects of these themes were further highlighted in the *Laming enquiry*¹² (2003), and subsequent inquiries continue to raise the same issues. On 24th June 2004 one year old twins in Sheffield were discovered in a life threatening condition as a result of serious neglect. The subsequent inquiry (Cantrill 2005) identified a failure of professionals to recognise, share and act on indicators of neglect and abuse. In this case the GP practice had knowledge of the family history and pattern of non-attendance for health care appointments, yet staff within the primary health care team failed to piece information together, understand its significance and act accordingly. In March 2006, Child B in Westminster was admitted to hospital with serious injuries and suffering from neglect, despite being monitored closely by health and children’s

¹¹ Full title: *Report of the Committee of Inquiry into the care and supervision provided in relation to Maria Colwell*

¹² Proper title: *The Laming enquiry into the death of Victoria Climbié*

social care services¹³. The Executive Summary of the Westminster Serious Case Review (Lock 2006) noted an ‘inappropriate rule of optimism’ (citing Dingwall et al. 1983) by professionals, with intervention and assessment being too adult focused. It also noted professionals had overlooked the importance of communicating directly and separately with the child and ensuring that the child’s needs and views were at the centre of the process.

It remains a cause of concern that despite the plethora of guidance and discussion, the lessons from these inquiries have not apparently been learnt. A review of serious case reviews (Sinclair & Bullock 2002) noted that case reviews were loath to criticise GPs for fear of compromising inter-agency relationships. This suggests that GPs have been accorded a different status to other professional groups within the child protection network and concurs with the findings of Lupton et al. (2001) that GPs themselves see their role as quite separate from the team based approaches of other health care professionals. The GP’s priority normally would be to the presenting individual and seeking to meet medical needs, often through referral to specialist health services. In the case of child protection concerns, referrals may raise a number of different issues, especially where these are seen to be socially related rather than an exclusively medical problem and are made to non-health professionals. There appears to be a need to understand the individual role of the GP and to be able to balance this within a multidisciplinary response to safeguarding children.

1.6 THE GP CONTRACT

Major change has also taken place in relation to GP Contracts. The NHS Act 1946 provided a family doctor free of charge at the point of contact to the entire population. The state entered into a contract *for* service with GPs funded by way of capitation as opposed to a contract *of* service (Rivett 1998). The period from the 1950s to the 1980s saw the use of financial incentives to encourage GPs to develop their practices and the emergence of the primary health care team, which included health visitors, who began to work closely with the GP in relation to child health care. As the NHS developed, GPs fought hard to maintain their status as independent contractors, while accepting a

¹³ See Glossary for references to children’s social services

political agenda of moving towards a stronger emphasis on preventative and promotional health services (Leathard 2000). In the 1990s, a policy framework emerged that sought to regulate and measure the performance of GPs through targets and financial incentives for such things as immunizations, health surveillance for under-fives and support for doctors working in deprived areas (BMA 2008). For children in need or at risk, these measures provided more opportunities for oversight of their welfare consistent with Bannon and Carter's (2002) views on the holistic role of GPs (See section 2.3).

The opportunity for practices to become budget fund holders enabled GPs to enlarge the scope of primary care (Klein 2006), and many employed more specialist nurses to manage tasks such as immunization and the management of chronic conditions. For parents and children, this has meant that they may be less likely to see a doctor for routine health appointments and, for the GPs, that they may know their families less well than previously. Fund holding was abolished in 1997, but the role of GPs as purchasers has expanded and the delegation of tasks to other professionals such as nurses has continued.

The NHS Plan 2000 strengthened the 'command and control system' that the government had established in the 1997 White Paper *The New NHS: Modern – Dependable* (Klein 2006). This heralded the establishment of the new General Medical Services' GP Contract 2004, which was designed to improve the quality of care through a national framework of standards. The Quality and Outcomes Framework (QOF) gave GP practices financial incentives to improve standards in the domains of clinical, organizational and additional services (such as health surveillance), and the patient experience. The new contract incentivised greater quality of health care for children through child health surveillance, but included limited reference specifically to safeguarding and child protection issues (BMA 2008). The contract makes reference to protected learning development time for GPs and refers to child protection as an example of a core subject that GPs should cover and as an example for a significant event review (Education Indicator 7). However, unlike cardiopulmonary resuscitation (CPR) training, child protection training is not rewarded with Quality and Outcomes Framework (QOF) points (four are identified for CPR training for all practice-employed clinical staff in the preceding eighteen

months - Education Indicator 1). One point is awarded for the availability of Child Protection Procedures within the practice (Management Indicator 1). Measurable targets for the application of procedures for safeguarding children are not included, though these might be difficult to establish. The requirement that:

“Individual healthcare professionals should be able to demonstrate that they comply with the national child protection guidance, and should provide at least one critical event analysis regarding concerns about a child’s welfare ...” (BMA 2003)

appears to pay attention to child welfare but only ‘*if appropriate*’. The RCGP Child Protection Strategy (2005) aimed to address concerns and make recommendations strengthening requirements to prevent “*child care leaking out of general practice as a result of the GMS contract and the new recommendations for child health promotion*” (BMA 2003); see also Hall & Elliman (2003) and Hall & Sowden (2005).

The introduction of practice-based commissioning of services was anticipated by 2008/9 (DH 2004b). GP practices would be given “indicative” budgets by PCTS and be expected to balance their budgets. These measures would consolidate the GP practice as a business organization, with “payments by results”, while creating more accountability to the local Primary Care Trust (PCT) but not removing existing contract arrangements. It also opens up the opportunity for GPs to contract with other corporate providers to provide community health services, to prioritize preventive services and reduce referrals to hospitals. Talbot-Smith and Pollock (2006) note that changes in NHS provision (e.g. NHS Direct, nurse led “walk in centres”) have changed GPs’ longstanding monopoly over the provision of primary care services. With the emergence of Children’s Trusts, this could well have implications for child health surveillance, the location of health visitors and the oversight of health needs of vulnerable children.

The RCGP suggested in 2002 that the PCT has a role “*to ensure continuation of clear service standards for safeguarding children and promoting their welfare*”, and it has been suggested that PCTs should enforce these standards by building them into their contracts with GPs. GPs are likely to focus on clinical interventions that yield the greatest benefits for the greatest number of patients, along with financial rewards

through the QOF/budgetary systems; it may be difficult to prioritise aspects of child welfare and child protection which do not fit clearly into a clinical framework or the identified priorities of current financial models.

1.7 EXPECTATIONS OF THE GP ROLE IN SAFEGUARDING CHILDREN

The Government strategy current at the time of the study has implications for all the agencies providing services for children, who will have different professional values, priorities and models of working which will impact on their ability to work collaboratively as part of an inter-agency approach (Murphy 2004). For GPs, who regard the doctor/patient relationship of prime importance (Polnay 2001) and are keen to maintain good relationships with parents as well as children, this presents a particular challenge and can give rise to conflicts of interest. The assumption that GPs will automatically become a key part of an inter-agency network after traditionally finding themselves on the periphery of the child protection network (Hallett 1995) is questionable, and Reder and Duncan (2003, 2004) suggested that an inter-agency systemic mindset needs to be developed if there is to be an effective joint interprofessional approach.

GPs continue to be accorded “*a much more pivotal role in all stages of the child protection process than they typically assume themselves*” (Lupton et al. 2001, p 177), and this is likely to create dilemmas for them, not only with regard to their work with children and their families, but also in meeting the expectations of other professionals as to their role in safeguarding children. Given that GPs report that they infrequently come across child abuse (Polnay 2001), it may not be the case that they see themselves, or are seen, as significant players in the child protection process (see Section 2.3).

The context within which the GP works is relevant to this study, which seeks to explore the tensions and conflicts of interests for GPs in safeguarding children. The key themes emerging appear to be:

- The changing context of GP practice services (as outlined in 1.6) alongside the Every Child Matters agenda which seeks to promote greater inter-agency collaboration through the development of Children Trusts and Local Safeguarding Children Boards;

- Apparently conflicting expectations of GPs and other agencies as to how GPs can contribute to the protection of children, despite legislation and guidance about their role;
- The evolving professional environment of change, in terms of structures, policy and systems, which is also relevant to interpersonal as well as interprofessional relationships;
- the contentious and complex nature of clinical professional practice in this area.

This report presents a Review of relevant Literature, the project's Aims and Objectives, Ethical and Management arrangements, a brief summary of Methodology and Methods used, the Research Findings from each of the methods used, a Discussion of the tensions and conflicts of interest emerging from the findings across the study, and concludes with a Summary of the study and Implications for policy practice and research.

The section of the report that follows provides a Literature Review for this study.

SECTION 2: THE LITERATURE REVIEW

2.1 INTRODUCTION

This review of the literature focuses on the role of the GP in the recognition and management of child neglect and abuse, with particular attention to the possible conflicts of interest that may occur for GPs in this area.

A search was made of the following databases: CINAHL, MEDLINE, ASSIA, COCHRANE, INGENTA. The following key search terms were used - GPs and conflicts of interest, GPs and child protection/child abuse/child welfare/safeguarding children, GPs and consent/ confidentiality/ information sharing. More detailed searches were made of the British Medical Journal, the British Journal of General Practice and the Child Abuse Review journal. The following websites were also searched: Joseph Rowntree Trust, NSPCC, Kingston University library catalogue, DfES, DH and DCSF, GMC, BMA, Royal College of General Practitioners and Royal College of Paediatrics and Child Health for relevant articles and books.

The preceding section has highlighted the policy and guidance context and frameworks for safeguarding relevant to potential tensions and conflicts of interest. This section sets out key literature firstly in relation to definitions of and views on priorities in child abuse and child neglect. This is followed by consideration of literature on the role of the GP: the centrality (or not) of the GP in relation to safeguarding children; their model of working; the focus on the family; and their role with children with disabilities, and those from ethnic minority families. A discussion follows informed by the literature on the child protection process, the primary care team, and inter-agency working. Three key issues relevant to the study are then presented: confidentiality, information sharing, and training in child protection. The literature review concludes with a summary of the key themes arising from the selected literature.

2.2 CHILD ABUSE AND NEGLECT

Corby (2006) noted that as early as 1995 the British government accepted the view that child abuse and neglect are socially constructed (DH 1995) and presented the

treatment of children as a continuum from the acceptable/desirable through to significant harm/ seriously abusive. This is reflected in the more recent safeguarding guidance. *Working Together to Safeguard Children* sets out four broad categories of abuse, which are used for the purpose of registration on the Child Protection Register (before April 2008), namely physical abuse, emotional abuse, sexual abuse and neglect. These categories tend to overlap and children are likely to suffer from more than one type of abuse. The proportion of children registered for neglect out of the total number of children registered continues to rise, from 39% in 2002 to 43% in 2006 (DfES 2006).

Neglect is seen as an omission of appropriate care, can vary in severity over time, and is often cyclical, dipping above and below a threshold of concern. Referrals for neglect are less likely to be investigated or to be the subject of a child protection conference (Farmer & Lutman 2007). In their key messages from their analysis of serious care reviews 2003-5, Brandon et al. (2008) draw attention to the “*start again syndrome*” in cases of neglect, where each event is seen in isolation, and conclude that the “*policy emphasis on early intervention and prevention can make it harder for practitioners to make difficult decisions*” in cases of severe or prolonged neglect (p 105).

Taylor and Daniel (2005) noted that child neglect has traditionally been accorded a low priority in the continuum of abuse, but Stevenson (2007) promotes the view that neglect is an area where the GP as the leader of the primary health care team may be best placed to play a preventative and protective role. She states that in these cases “*there are sometimes complicating medical problems in the children; the interaction of these with the lack of effective parental care is often highly problematic*” (p 114). She goes on to highlight that neglectful parents often have difficulty meeting the health needs of their children and attending appointments. The significance of ‘did not attend’ as an indicator of neglectful care was highly relevant in the Sheffield Case (2005). This in turn can lead to a downward spiral in the health and care of the child. Stevenson points out that the neglect of children’s health care needs can be a key factor in the overall assessment.

2.3 THE CENTRAL ROLE OF THE GP?

The GP has a central role in the provision of primary health care and is seen by many as the first and last port of call in child protection (GMC: Opinion Leader Research 2005). The reasons are that GPs offer a comprehensive primary care service to all their patients from the ‘cradle to the grave’ within the context of a national health service with limited resources and competing priorities. Polnay (2001) suggested that the GP is in an ideal position to recognize when a child is potentially at risk, and Leheup (2001) reinforced this when she stated that ‘the best intervention is prevention’ (p 157). Bastable (2005) advocates a proactive role for GPs, stating that, although the GP contact with a child/family may be brief and infrequent and less once children attend school, the GP will be there before and after child protection concerns. Pre-school children see a GP on average six times a year while school age children will visit their GP two or three times a year (DH 2004). Bastable (2005) argues that the holistic family approach means GPs are well placed to develop systems to support the protection of children.

Bell (2000) reported that for GPs, child protection was a much less significant aspect of their work than for other colleagues and agencies and as a consequence it was given a much lower priority. Lupton et al. (2000) found that GPs saw fewer than 2 cases a year defined as child protection, and Polnay (2001) noted this may mean that the GPs’ level of awareness and ability to spot abuse is lower than for colleagues who have more experience in this area of work – underreporting the number of cases that a GP might identify. Reports from the NSPCC suggest that the incidence of abuse and death by abuse is significantly underreported and under-acknowledged (Cawson et al. 2000; Creighton & Tissier 2003). GPs are placed in a situation where there are high expectations around the role they could play in safeguarding children, while opportunities to develop expertise in this area of work may be limited.

In contrast to this noted low involvement of GPs, a study of children who died of abuse and neglect by Reder and Duncan (1999) found that more than one third of these children were known to primary health care teams but were not open cases to children’s social care services. Research into Serious Case Reviews of 40 child deaths or serious injuries (Sinclair & Bullock 2002) cited the high level of involvement of health professionals in the cases they examined, even though children’s social care

services departments were acknowledged as having the lead responsibility in respect of child protection at the time of the Reviews. GPs had substantial involvement with nine of the 40 children and 13 of the carers in the study over the previous two years before the incident causing death or substantial injury. GPs also had limited involvement with another 20 of the children and 23 of the carers. Overall this represented, for those parents/carers, greater involvement with GPs than with social workers or any other professional group or setting. In relation to the children in Sinclair and Bullock's study, the involvement of professionals with substantial contact was greatest with health visitors (in 16 cases), compared to GPs (9) and social workers (10). This suggested that health professionals and especially health visitors might be more significant and better placed than children's social care services in identifying potential risk to children.

These findings have been similarly reflected in the more recent serious case reviews for 2003-5 (Brandon et al. 2008), where GPs were involved over the last two years with 66% (31 of 47 families) and health visitors with 60% (28 families) of the families where a child was the subject of a serious case review and detailed information was available. In this intensive sample, 83% (39/47) of families were known to children's social care services (p 49/50) (children's social care), but at the time of the incident, social services involvement dropped to 64% (30/47). Brandon et al. note in their key messages that "*the families of very young children who were physically assaulted tended to have the least, or the briefest, contact with children's social care which put a greater onus on universal agencies to recognise signs of harm to children*" (p 101). The pressures on and patterns of work in universal services may then contribute to Brandon et al's identified "*start again*" syndrome when cases are closed or events viewed as isolated incidents, rather than as an incremental history.

In their *Position Paper for the Royal College of General Practitioners*¹⁴ in 2002, Bannon and Carter referred to the "*unique and continuing contact with children and*

¹⁴ Full title: *The Role of Primary Care in the Protection of Children from Abuse and Neglect. A joint position paper with the Royal College of Paediatrics and Child Health and endorsed by the NSPCC*

families”, that gives GPs and other members of the primary health care team the opportunity to recognize risk situations, engage with and support parents/carers/families and children, and provide vital information to inform assessment, planning and intervention strategies and conferences. However, they acknowledged that despite this position there was a perception by other agencies, and especially from children’s social care services, that GPs did not always fulfil their roles and responsibilities in child protection. The mismatch between the reality of GP involvement and the expectations upon them with regard to safeguarding children was, in their view, a weak link in the inter-agency chain and needed clarification.

2.4 THE GP MODEL OF PRACTICE

GPs operate from a position of relative managerial autonomy (Lupton et al. 2001). They are trained to practice within a medical, bio-scientific model which focuses on evidence based practice and relies on referral to an expert to deal with the more complex problems. However, the duty to act in the best interests of the patient leads GPs to take a more holistic family approach (Bastable 2005) and to consider social and environmental factors during their consultations. This is particularly relevant for children at risk of child abuse and neglect and is reflected in the BMA guidance (2004) on doctors’ responsibilities in child protection.

Goldthorpe (2004) noted that GPs appear to lack confidence in the child protection procedure and fear that once the process has started, it cannot be stopped. This feeling of loss of control by GPs who normally hold high status and power can deter GPs’ participation. Polnay (2001) explained such a lack of confidence as being due to their isolation, non-involvement and lack of trust in the inter-agency network, and fear that their relationship with parents will be compromised. Cooper et al. (2003) identify the importance of trust, authority and negotiation as key principles for an effective system of child welfare.

Bannon and Carter (2002) noted that a high level of anxiety amongst doctors often created a barrier to effective child protection work. There were also elements of professional denial and a failure to recognise abuse. Keys (2005) found that some doctors manage their anxiety by distancing themselves from the process. Lupton et al. (2001) suggested that the shift from a dominant medical model to a socio-legal model

had downgraded the importance of ‘medical know how’ in child protection matters, leaving GPs feeling more vulnerable. Their concern about the adversarial and prescriptive nature of the process created ambivalence for some GPs about the validity of the process, and this was resolved by leaving other agencies to deal with child protection matters (Hallett 1995, Lupton et al. 1999). There was an expectation that children’s social care services would be the lead agency co-ordinating the inter-agency response and that they would be proactive if they required anything of the GP. Morrison (2000) noted that non-statutory agencies acquiesced in allowing children’s social care services to run the show, in return for minimal responsibility with regard to child protection issues. Lupton et al. (2000) found that GPs saw their role as peripheral to the role of others in the network, and in their analysis of child protection networks referred to GPs as the ‘sleeping partners.’ *The Report into the Death of Lauren Wright* (Norfolk Health Authority 2002) provided evidence of the dangers inherent in this attitude. It would appear that GPs are often unsure as to whether they are part of the child protection network, and this can influence how they respond in situations where children may be at risk.

2.5 THE FAMILY FOCUS

The literature identifies that GPs view their role with children and their parents quite differently to other professionals. GPs have to work through and with parents and wish to care for children within the context of their family (Bastable & Horwath 2004). They do not have direct access to children and as such need to nurture a relationship of trust with the parents/carers of children who need their services. From a more general health care perspective, GPs are particularly concerned that their actions do not deter parents from seeking medical help for themselves and their children.

The GP is likely to start from a family welfare perspective of safeguarding children, where in all but exceptional circumstances, the doctor-parent-child relationship may assume the needs and the interests of the children and their parents will be the same and that the parent will be focused on the best interests of the child. This has implications for collaboration with other agencies who will not necessarily view the child’s needs and those of the parents as being coterminous (Murphy 2004). Polnay

(2001) stated that GPs are not used to putting the needs or rights of one patient above another and, in the case of child protection, this can lead to conflicts of interests and divided loyalties. She suggests that this conflict of interest goes beyond the consultation with the parent/child to the individual consultation with adult patients who are parents, where medical/social problems could pose risks to children. She notes the conflicts for a GP of seeing one patient and thinking of another, when the more vulnerable person, namely the child, is not present.

Conflicts of interest may arise for the GPs when addressing the issue with the parents and taking action which could compromise the doctor/patient relationship (Lupton et al. 2001), in the balancing of competing needs of patients (and third parties), key stakeholders and themselves (Palmer et al. 2006), and in balancing the needs of the individual patient against the public good (Berger 2005).

The GP's approach can carry with it the 'rule of optimism' (Hallett & Birchall 1992, DH 2002 - citing Dingwall et al. 1983) and a 'wait and see' approach, which may not always be in the best interests of the child (Bastable & Horwath 2004). Murphy (2004) suggested that the policy context for safeguarding children, where the child protection system is built around the child's right not to be abused and the parent's right not to be interfered with by the state, is the crucial dilemma facing all professionals working in this field. This can pose difficulties for GPs working within a family context and give rise to conflicts of interest especially in less clear cut scenarios, where abuse and neglect may be suspected, but not easily identifiable.

Hallett and Birchall (1992) found that the tendency of GPs to have a lifelong commitment to patients and more geographical stability in their careers could make them less likely to want to raise issues of concern. Farmer & Owen (1995) observed that where GPs had seen more of the parents than the child, they sometimes took the parents' side and where they did get involved in the process and attend case conferences, they would often advocate for the parents. Stanley et al. (2003) also found that GPs perceived part of their role was to advocate for family members. Goldthorpe (2004), considering the GP's position from a legal perspective, suggested that many GPs are so preoccupied with their own concerns that they are often unable to see things from a child's perspective. She argued that GPs may be worried about

the loss of trust of the parents, the loss of control within the child protection process, the time child protection can take, and the impact on their reputation, rather than the issues facing the child.

Keys (2005) argues that GPs often have a wealth of knowledge to help identify children at risk at an early stage. GPs and the Primary Health Care Team may already have knowledge of identified risk factors present in families, such as parental mental health problems, addiction or domestic violence. *Child Protection: Messages from Research* (DH 1995) challenged the notion that GPs know their patients as well as is suggested, citing increased workload, a focus on time limited consultations within the surgery, 'less ownership' of patient lists and the use of co operatives or locums for 'on call' services as changes that have restricted the GPs' opportunities to develop an in depth knowledge about families. This disparity between GPs' perception of their knowledge of families and the perception of other professionals has yet to be resolved and remains a potential obstacle to be overcome in the promotion of joint working.

2.6 THE GP ROLE WITH CHILDREN WITH DISABILITIES

Working Together to Safeguard Children notes that children with a disability are at increased risk of abuse and that the presence of multiple disabilities increases the risk of abuse and neglect. The National Working Group on Child Protection and Disability (NSPCC 2003) suggested that disabled children are three times more likely to be abused than non-disabled children and expressed concern that the safeguarding of children with disabilities has still not been brought fully into the child protection system. Cooke and Standen (2002), in their year long study of two local authorities, found that children with a disability, who were the subject of a child protection conference, were less likely to be put on the child protection register than non-disabled children. Taylor and Daniel (2005) also observed that there is a tendency to allow a standard of care for children with disabilities that would not be acceptable for non-disabled children. Keys' research (2005) noted GPs' difficulty in attending child protection training forums, a place where awareness of the special safeguarding needs for children with disabilities could be raised.

2.7 THE GP ROLE WITH CHILDREN FROM BLACK & ETHNIC MINORITIES

Children from black and minority ethnic families are significantly over-represented among looked after children and those on child protection registers (Welbourne 2002). *The Children Act Now* (DH 2001) identified that children from black and minority ethnic families receive a differential service compared with white children and families. Preventive service input was lower, and a higher proportion of minority ethnic children, who were 'looked after', were in local authority care on a compulsory basis. In March 2002, 17% of children registered as receiving a formal child protection service were of minority ethnic origin (DfES 2004b). Chand and Thoburn (2006) noted that when these figures are analysed by ethnic group, white children and those of Asian origin were under represented, while those of mixed heritage and the 'other' groups were over represented. The combined group of African-Caribbean and African children were neither over nor under represented.

Webb et al. (2002) identified barriers to effective work with black and ethnic minorities among professionals including GPs, which could be addressed by appropriate training. These include "*denial of abuse in ethnic minority communities, cultural differences in attitudes to disability and child-rearing, the vulnerability of women in highly patriarchal communities, difficulties in providing mental health services across cultural boundaries and a lack of settings in which to provide appropriate alternative care and places of safety.*" Chand and Thoburn (2006) also identify the complexity of child protection concerns which do not fit neatly into one specific category of abuse, and point to the importance of practitioners understanding the particular issues for the minority ethnic families they are working with, in the context of their cultural environment. Well-established GPs in areas with a high minority ethnic population may be best placed to have this specific knowledge and awareness.

Where families come from ethnic minority groups, separating out the needs of the child from the context of their culture may not always be clear cut and this may give rise to conflicts of interest especially for GPs of a similar cultural background.

2.8 THE CHILD PROTECTION PROCESS

GPs have a duty to inform children's social care services, when they believe a child has suffered or is at risk of suffering significant harm. They also have a responsibility to ensure that children on the child protection register are easily identifiable to all members of the primary health care team. Polnay (2001) suggested that, as the thresholds for social work intervention increase, a greater responsibility rests with the primary health care team to safeguard children.

Studies into GPs' limited involvement in the child protection process and non-attendance at child protection conferences, (Lea-Cox & Hall 1991, Simpson et al. 1994, Birchall & Hallett 1995, Polnay 2000 & Morgan 2002), have cited the length of time for conferences, the timing, the difficulty of arranging locum cover and other priorities as key explanations for their absence. A GP will normally allow ten to fifteen minutes for a consultation, while in contrast a child protection conference is likely to take up to two hours. It would be unusual for a GP to spend two hours at one time on one patient except in very serious circumstances. However, both Hallett (1995) and Polnay (2000) in their studies concluded that even when the timing of a conference is arranged to suit a GP, they do not attend. Another key factor is the GPs' lack of understanding of the inter-agency roles (Lupton et al. 2001, Keys 2005).

Gibbons et al. (1995) analysed the attendance of different professional groups at case conferences in eight local authorities. GPs were the least represented professional group in this study with 19% attendance. Hallett (1995) also found GPs were the largest single group of non-attendees and were minimally involved in the identification and referral of child protection. Murphy (2004) considered that structural and organisational barriers deterred GPs from engaging in case conferences. As a self regulatory group, where they are used to being in control over the content and process of what they do, they find the loss of power to a multi agency process headed by children's social care services difficult and will tend to avoid these forums. Bell (2000) in her study noted that there was limited discussion of medical issues at conferences.

Other professionals appear to have high expectations of the GP's knowledge of social and family circumstances, as well as medical information, that they will be able to

contribute to a conference discussion. Morgan (2002) in her study found that GPs explained their limited contribution to case conferences as being due to the fact that they did not have information to give. Polnay (2000) in his survey of GPs noted that around 50% of the GPs felt that social workers overestimated their role with the family.

Hallett (1995) found that GPs tended not to put things in writing. She noted that the sharing of confidential information was an issue for GPs and that sometimes this could be managed by a GP neither being aware of nor acknowledging their concerns about a child. Where GPs did write reports, they could be very influential. The National Working Group on Child Protection and Disability (NSPCC 2003) reported that they had come across instances, where GP reports were given far more weight than school records showing specific injuries or reports from respite foster carers who had intimate knowledge of the child and their family. Despite the requirement in *Working Together to Safeguard Children* that all professionals should make every effort to attend a case conference and, failing this, should provide a report, GPs' recorded attendance at conferences, or the provision of reports when they cannot attend remains low.

The findings of Lupton et al. (1999) suggest that some doctors take a linear view of their role in child protection. These GPs viewed their contribution as being most significant in the pre-referral stage – before passing it to children's social care services – rather than seeing themselves as having an ongoing contribution to make to the subsequent protection plan for that child. This also links to the pattern of GP involvement with other conditions, where once a referral has been made to a specialist, the GP will await feedback about diagnosis, treatment and management rather than necessarily taking an active ongoing role. Murphy (2004) noted that inter-agency collaboration tends to diminish over time, and the GPs can find themselves out of the information sharing loop.

Government policy and inter-agency protocols continue to be based on the assumption that GPs are fully involved in the child protection process, despite evidence to suggest this is not always the case.

2.9 THE PRIMARY HEALTH CARE TEAM

The GP heads up the primary health care team, and many GPs look to health visitors to take the lead role in safeguarding children. Birchall and Hallett (1995), in their assessment of interprofessional working, found that two thirds of GPs would contact the health visitor if they had any child protection concerns. Shaw (1996) identified a similar pattern in South London, where a number just fewer than 50% of GPs interviewed stated they would discuss child protection concerns with their health visitor. Representation from the Primary Health Care Team at case conferences is much more likely to be a health visitor, rather than a GP (Farmer & Owen, 1995). Stanley et al. (2003) found in their study of depressed mothers, that GPs tended to nominate health visitors above all other professional groups as the people best placed to take a lead role where there was cause for concern, and that they felt that risk was best managed in the primary care setting.

2.10 INTER-AGENCY WORKING

Barter (2001) asserted that *“the protection of children is too important to be left to any one profession or agency”* (p 273). Ward et al. (2004) suggested that *“shared information about the aetiology and long term consequences of abuse, the development of common understanding and a shared language, as well as the identification and agreement of common thresholds of concern, would improve inter-agency working”* (p 107). Stanley et al. (2003) in their study cast doubt on the suggestion that GPs could bridge the gap between child care issues for children where parents had a mental health difficulty, citing their lack of expertise in this area as a key mitigating factor. Bastable and Horwath (2004) highlighted the importance of the GP to inter-agency collaboration, because of their potential ability to recognize problems early in their course and because of the family context within which they work.

Hallett (1995) observed that inter-agency work functions as a communication network, rather than a system of support and collaboration. The failures and difficulties around communication are long standing themes in child protection. Stevenson (1989) noted that territorialism, status and power, competition for resources, differing priorities, differing value systems and disrespect for each other's

expertise were all factors impacting on communication between agencies. Taylor and Daniel (2005) pointed out that GPs are not an agency but are independent practitioners within a health care setting, where professionals have differing distinct roles and often have little contact with each other. Easen et al. (2000) emphasised the importance of people factors and of personally knowing others in the network. They see the lack of continuity of staff as a key obstacle to the forging of effective networks. While GPs themselves appear to be a stable group, other professions such as social workers appear to have a relatively high turn over of staff. *Keeping Children Safe* acknowledged that organisations give a different level of priority to safeguarding children and work to different standards, which in turn makes collaboration and joint working difficult. Working collaboratively with other professional groups conflicts with the traditional independent autonomous role of the GP.

2.11 CONFIDENTIALITY AND THE SHARING OF INFORMATION

The sharing of information raises issues of confidentiality for all agencies but in particular for GPs, where information sharing is strictly regulated by the GMC (2004). The test of disclosure is one of proportionality. The key test is whether the proposed information sharing is in the 'public interest', on a 'need to know' basis and 'a proportionate response', to achieve the objective of safeguarding the welfare of children.

Bastable and Horwath (2004) explored these dilemmas in a workshop with doctors and found that participants were far less hesitant about information sharing within the primary health care team than information sharing outside the team. Where they did not have the consent of the patient/parent, they were very reluctant to share and exchange information outside the team, unless there was a proven or very strong suspicion of a child protection concern.

Polnay (2000), in exploring the opinions of GPs about child protection conferences, found that 25% of GPs felt that social workers did not understand the confidentiality issues for GPs and 33% felt they did not understand the GPs' responsibility to the parent as well as the child. This lack of understanding and lack of trust in other agencies to keep information confidential and use it appropriately has been seen as a key barrier to effective information sharing (Reder & Duncan 2003).

Richardson (2003) gives a personal reflective account of her own experience of the child protection procedure and talks of loose confidentiality and wide ‘information sharing’ where opinion becomes fact. She does not include her GP in this, who she reports tried to advocate for her, when her emotional reaction was interpreted to suggest that there was evidence of emotional abuse. The Laming Report (2003) also highlighted how information can become misinterpreted with a blurring of fact and opinion.

A key issue for GPs around sharing confidential information appears to be whether they hold the information in the first place and whether they know what information is relevant to share. Murphy (2004) emphasised the impact of differing professional perspectives as to what is important and who needs to know, quoting Calder (2003): “*What seems essential to communicate for one may seem a breach of confidentiality or peripheral to another*” (p 41). Munro (2005) emphasised the importance of the professional’s ability to collect the necessary information, to interpret it accurately and to communicate it clearly to the relevant people.

2.12 TRAINING IN CHILD PROTECTION

Pre- and post-graduate training about child abuse has developed in recent years and is a requirement for new GP Registrars. There is no subsequent national requirement for GPs to attend training updates. Bannon et al. (1999) assessed the perceived training needs of GPs and found these tended to be reactive, as opposed to proactive, and centred on the identification of abuse and the legal context. A later analysis of training needs (Bannon et al. 2001) also identified the maintenance of a working relationship with the family and an awareness and involvement in local procedures as further areas where GPs felt they needed support. Lupton et al. (2001) in their study found that, while all of the ‘designated’ child protection health professionals had received some form of training in identifying signs and symptoms of abuse, only four out of seven designated professionals and three out of twelve ‘named’ professionals had received any inter-agency child protection training with children’s social care services and the police. Laming (2003) noted the impact of differing perceptions of power and status and recommended that all disciplines of staff working in child protection need to be trained to be able to challenge the views of other professionals including doctors.

Afza et al. (2007), in their PCT audit of GPs' knowledge and awareness of child protection issues, found there was a poor uptake of training by GPs, with a low level of awareness of policies and procedures. They concluded that child protection training was not considered a priority by GPs, efforts to raise awareness had not translated into GPs having more factual knowledge, and overall things had not improved since the studies of Bannon et al. in 1999 and 2001. Baverstock et al. (2008) in their study on the uptake of child protection training within a general hospital also note that better training may not necessarily lead to better outcomes for children and that there has been limited research into the effectiveness of training

As might be expected, a key difficulty for inclusive inter-agency training is the limited take up by GPs. Successful training initiatives for GPs appear to be within the primary care setting as opposed to multi agency (Bannon et al. 2001). Weir et al. (1997) undertook a training programme for GPs in Hackney, which successfully engaged GPs and other primary care workers but was not multi-agency. Keys (2005) specially targeted training to meet the needs of health professionals in an area of Scotland. This drew on the expertise of other agencies, but the participants were all health professionals as opposed to multi-agency workers. It achieved successful outcomes in terms of greater awareness of child abuse procedures and the importance of inter-agency communication, but was not an inter-agency event.

Where GPs did undertake child protection training, it appears to have led to more referrals to other health professionals, paediatricians and children's social care services. This is in line with the evidence of studies looking at training outcomes for hospital doctors and support staff (Polnay & Curnock 2003, Bajaj et al. 2006). Polnay (2000) suggested that there is a direct correlation between training and improved communication. Feedback from training indicates that it has led to a greater understanding by GPs of the roles of other professionals working to safeguard children (Keys 2005). It did not however, impact on the attendance of GPs at case conferences (Polnay 2000).

Murphy et al. (2006), in considering inter-agency training needs, pointed to the need to have an agreement on what is good inter-agency practice. In response to Lord Laming's criticism of training for all professional groups involved in child protection,

they proposed the establishment of clear standards of individual agency roles and responsibilities within the individual agency and within the context of the roles and responsibilities of other agencies.

2.13 CONCLUSION

Munro (2002) highlighted “the importance of gaining cooperation from a family” as particularly significant in child protection, both in terms of clarifying the quality of information and perceptions, and in enabling “*work with the parents to try to promote safe and adequate care*” (p 92). The aim is to minimize the impact of intrusive interventionist approaches and maximize more positive outcomes for children, parents and families. *Child Protection: Messages from Research* (1995, p 52) identified five features of “efficient” practice of which four are pertinent to this study:

- Sensitive and informed professional/client relationships
- An appropriate balance of power between the key parties
- A wide perspective on child abuse
- A determination to enhance the quality of children’s lives

Of particular relevance to this study is the identification of a potential conflict of interests, “*when both the abused or neglected child and the person suspected of responsibility for the abuse or neglect are registered with the same doctor.*” The BMA guidance (2004) affirmed the primary responsibility of doctors to the child “as the more vulnerable party”, giving priority to their interests over the suspected abuser’s, while seeking to treat all parties “*sensitively and professionally*”, respecting both parties’ wishes as far as the best interests of the child are concerned (p 4).

This literature review has highlighted that there is a considerable range of opinion around the GP’s role in safeguarding children. Despite this, inter-agency policy continues to be based on the assumption that GPs can and do play a pivotal role in child protection. This would appear to create tensions in role and relationships for GPs beyond the conflict of interest they face with regard to managing both children at risk and their parents as patients. The literature suggests that these tensions are inter-related. Factors identified in the literature contributing to these tensions are: levels of GP confidence, knowledge and training around safeguarding children; confidentiality

and the sharing of information; and trust between the GP and patients and the GP and other professionals.

A further area of conflict may be inherent in the models of scientific knowledge and training associated with medical practice. These may not be easily adapted to the complexity of explanations of some examples of child abuse or neglect, drawing on social constructs rather than based on diagnosis of disease and recognition of pathology. If child abuse or neglect is less easy to identify and more challengeable, and requires a response through inter-agency collaboration, then it may threaten the doctor's relationship with the family. A final area of conflict may lie in the moral contract between medical professionals and society, based for the purposes of this study in the particular expectations of and historically special respect accorded to GPs by patients.

Acknowledging that "*protection (of children) is best achieved by building on the existing strengths of the child's living situation, rather than expecting miracles from isolated and spasmodic interventions*" (DH 1995, p 52), this study seeks to explore the particular contribution GPs make and the constraints, tensions, conflicts and dilemmas they and others perceive in effecting a contribution to the safeguarding of children.

The following section identifies the Aims and Objectives, and the ethical and management arrangements for the project.

SECTION 3: AIMS AND OBJECTIVES

3.1 AIMS AND OBJECTIVES

The study aimed to:

1. Explore the nature and consequences of tensions and conflicts of interest for GPs in safeguarding children, (particularly when the GP has both a child or young person and an "alleged perpetrator" as patients in child protection cases);

taking account of key factors for GPs as identified by Bastable & Horwath in 2004:

- The doctor/patient relationship, considering who is the patient and the balance of family interests versus the child's, particularly where the family/parent will provide the main support or environment for the child;
 - Confidentiality, consent and information sharing;
 - Risk considerations, knowledge of child protection and thresholds of concern;
 - Approaches to decision-making including access to advice/training and the nature of partnership;
 - Consideration of issues of ethnicity and disability for both children and GPs.
2. Evaluate how these tensions and conflicts are seen from a range of professional, parent and child perspectives within the current policy context, and taking into account their views of the significance and expectations of the GP role
 3. Consider ways of managing these tensions and conflicts of interest to promote best practice and clarify the role of the GP as part of the interprofessional response.

Research Questions were framed as follows, and Table 1 in Section 4 identifies how the research questions were to be addressed in the different study methods:

- a. What kind of conflicts are raised when a GP has both a child or young person and an ‘alleged perpetrator’ as patients in child protection cases, and how often have these occurred?
- b. How are these conflicts of interest informed and affected by current policy and law, inter-agency structures, ethical considerations and guidance from professional bodies relating to, for example, information sharing in child protection cases?
- c. How are these conflicts seen from a range of professional perspectives, including GPs, other professionals involved in child protection, and professional medical bodies?
- d. How are these conflicts of interest seen from the perspective of children/young people and parents/carers, and would it make any difference to how they would behave?
- e. What are the consequences of the conflicts of interest for GPs, for children, for parents and for the relationships between these people?
- f. Are there any particular issues in these conflicts affecting children from black and/or minority ethnic families or children with disabilities?
- g. In what ways do GPs resolve these conflicts of interest; from whom do they seek advice?
- h. What best practice can be identified in relation to managing conflicts of interest and what recommendations can be identified from this for managing them?

3.2 DISSEMINATION OF FINDINGS

Alongside the final report to DfES/DCFS/DH and journal articles, it was also hoped to contribute to the development of best practice through the presentation and discussion of findings with GPs, and at relevant national and international conferences with an interest in interprofessional approaches to child protection.

3.3 ETHICAL APPROVAL AND GOVERNANCE

The research project was submitted to the South East Multi Centre Research Ethics Committee (Ref No.06/MRE01/71) on the 9th August 2006. It received approval in principle on 15th August 2006 and full approval on 3rd October. Submissions were then made to the Research and Development boards of the South London and Shire County Primary Care Trusts. Approval was received from both the South London board and the Shire County board on the 16th October 2006.

Ethical approval and governance guidelines are designed to promote high quality research that adheres to a code of practice, which protects the safety, dignity and well being of research participants. This requires that all participants receive clear information about the project, give informed consent to their participation, understand what happens to the information they provide and are aware of their right to withdraw from the project at anytime. This project while adhering strictly to the advice and guidelines provided by the Ethics Committee was aware that the detailed information sheets provided to participants proved somewhat overwhelming and deterred some people from taking part. This was particularly apparent in the GP sample, who reported limited time to read all the information provided, and for the Focus groups, who found it difficult to engage with the written documentation and expressed a preference for this to be explained to them face to face.

3.4 PROJECT MANAGEMENT

A multi disciplinary Steering/Advisory Group was established at the beginning of the project and met on a quarterly basis for the duration of the project. This group included representatives from the children's social care services within the two Primary Care Trusts (PCTs) identified for the study, representatives from the British Medical Association and Royal College of General Practitioners, academics from the nursing and social work professions, the Safeguarding Initiative project lead for the Department for Education and Skills/Department of Health and representatives of service user groups, as well as members of the research team. The Advisory group oversaw the governance of the project, advising on relevant new policy and professional developments, ensuring deadlines were met, reviewing the risk and data

management strategy, and problem solving in relation to access, ethical or research method issues.

The following section provides a brief overview of the Methodology, Methods and Samples used in the study.

SECTION 4: METHODOLOGY, METHODS AND SAMPLES

4.1 METHODOLOGY AND METHODS

This was an exploratory mixed methods study drawing on both quantitative and qualitative methods, focussing particularly on GPs in two contrasting Primary Care Trusts (PCTs) and groups of GPs accessed through training events.

The research was informed at all stages by:

- An extensive literature review on the role of GPs in safeguarding children, to include previous and current research and a review of recent policy and guidance
- The collection of demographic and child protection data in the two PCTs

The methods used to collect data were:

- Questionnaires with GPs from 2 PCTs and training events (*n* = 96)
- Interviews with GPs (a subset of the questionnaire respondents) (*n* = 14)
- Interviews with Key Stakeholders: Local Safeguarding Children Board (LSCB) professionals and representatives of ethnic minority and disability groups (*n* = 19)
- Focus Groups to provide the perspective of service users: young people and parents or carers, and an ethnic minority group (*n* = 3)
- A Delphi Panel (*n* = 25) to establish a consensus view on the GP role and conflicts of interest.

The methods as applied to the research questions (3.1) are detailed in Table 1, below.

4.2 THE PRIMARY CARE TRUSTS IN THE STUDY

The two PCTs were selected in consultation with the Steering Group to provide contrasting populations in terms of ethnicity, level of deprivations - as measured on the Indices of Deprivation (OPDM 2005), number of children on the child protection register (DfES 2006), and contrasting locations. The two PCTs who agreed to participate were:

- A PCT area (recently reconfigured) within a Shire County outside London,
- A South London borough with a mixed population.

Table 1: Cross-reference between Research Questions and Research Methods

Research question	Research Method
a) What kind of conflicts are raised when a GP has both a child or young person and an "alleged perpetrator" as patients in child protection cases, and how often have these occurred?	Questionnaires to GPs Interviews with GPs Focus groups with parents/carers and with young people Delphi discussion†
b) How are these conflicts of interest informed and affected by current policy and law, inter-agency structures, ethical considerations and guidance from professional bodies relating to, for example, information sharing in child protection cases?	Collection of demographic and child protection data Questionnaires to GPs Interviews with GPs Interviews with key stakeholders
c) How are these conflicts seen from a range of professional perspectives, including GPs, other professionals involved in child protection, and professional medical bodies?	Delphi discussion Questionnaires to GPs Interviews with GPs Interviews with key stakeholders
d) How are these conflicts of interest seen from the perspective of children/young people and parents/carers, and would it make any difference to how they would behave?	Focus groups with parents/carers and with young people
e) What are the consequences of the conflicts of interest for GPs, for children, for parents and for the relationships between these people?	Focus groups with parents/carers and with young people
f) Are there any particular issues in these conflicts affecting children from black and/or minority ethnic families or children with disabilities?	Interviews with GPs Delphi discussion Interviews with key stakeholders
g) In what ways do GPs resolve these conflicts of interest; from whom do they seek advice?	Interviews with GPs Questionnaires to GPs
h) What best practice can be identified in relation to managing conflicts of interest and what recommendations can be identified from this for managing them?	Interviews with GPs Focus groups with parents/carers and with young people Delphi discussion

The relevant demographic information is included in Table 2. The South London borough had a higher overall population, higher minority ethnic group population, higher rank of deprivation (lower value), and a higher ratio of children on the child protection register (CPR).

Table 2: Demographic data on the Sample PCTs

PCT	Population	White (as %)	Largest minority ethnic groups	Children on CPR in 2006	Average rank of deprivation
Shire County	245,356	96%	Indian, Chinese	60 (45,732) [†]	323, 349 (2 areas)
South London	330,688	78%	Black African, Black, Indian, Caribbean	241 (72,448) [†]	139

[†]total aged 0-15 in population

The distribution of child protection cases is clearly biased towards the South London PCT (Test 1: $p < 0.004$)¹⁵.

4.3 PURPOSES OF THE STUDY METHODS

GP Questionnaires

The questionnaires (see Appendix 1, Document 2: GP Questionnaire) were designed to gather demographic data about the GP and their practice, and quantitative data about the GP's role in child protection. The questionnaires also allowed the GPs to provide qualitative data as direct comments on their experience. The questionnaire sought to find out about the GP's knowledge of child protection procedures and from whom or how they would normally seek advice and guidance. The rationale behind this was that the GP's level of awareness of child protection issues was relevant to their ability to identify the problems, dilemmas and conflicts of interest that they may

¹⁵ The details of all statistical tests are provided in *Annex 2* and only noted in the text if significance is established. The value for p that is given is the probability that the null hypothesis could be valid. Where the limiting value is less than 0.001, this is stated as $p \approx 0$.

experience when managing concerns about a child's welfare. The GPs were not specifically asked to identify conflicts of interest, although the questionnaire was designed to draw out practice issues for GPs. A pilot version was tested with four GPs.

GP interviews

The interviews were designed as 'active interviews' that gathered relevant information about dilemmas for GPs and allowed for some 'collaborative discussion' around the wider agenda of safeguarding children (Holstein and Gubrium 1995).

Key Stakeholders interviews

The interviews were designed to test out the perceptions of professionals operating at a strategic level within the two PCTs and the relevant LSCB on the role of the GP in safeguarding children and their views on the inclusion of the GP in the inter-agency network. Selecting Key Stakeholders from the same PCTs was expected to ensure that they would share their context of practice.

Key stakeholders were also selected to include representatives from minority interest groups that were significant to the project but not otherwise included.

Focus groups

Focus groups were seen as a way of gaining the views of a range of patients (including young people or parents/carers of children and an ethnic minority community) about the GP role in child protection and the potential conflicts of interest this could raise for GPs.

The focus groups were designed so that participants could discuss their expectations of their GP, both in maintaining confidentiality and in sharing information relevant to child welfare concerns (Appendix 4, Document 2: Focus Group Plan). The groups were asked to explore the dilemmas raised and consider how GPs might manage such consultations and potential conflicts of interest.

The Delphi Panel

The purpose of the Delphi panel was to complement the views of other key stakeholders in the study on expectations of GP practice and draw on a range of

expertise to develop an independent, collective view of principles and conflicts of interest for GPs. It was anticipated their suggestions for appropriate interventions based on a series of vignettes would provide a suitable reference point for the views of other professionals that could contribute to the design of professional development materials for GPs.

4.4 COMMENTS ON THE SAMPLING PROCESS

GP Questionnaires

The research proposal identified that a sample of 400 GPs would be invited to complete a questionnaire, with 150 selected from each PCT and 100 from training events. At the start of the project, in October 2005, the number of GPs in the Shire county PCT was 170, and 225 in the South London PCT and it was decided to invite all 395 GPs in these two PCTs to participate.

A further 175 questionnaires were distributed at training events for GPs between late October and early December 2006 - i.e. a total of 570 overall. Access to three training events was arranged through local Deaneries, Faculty and the RCGP. Access to three further events was arranged by direct contacts through the researchers and members of the Steering/Advisory group. Many of the event organizers approached responded stating there was insufficient time and space for discussion of the research project.

Since both attendance at the training events, and completion of the questionnaire are self-selecting processes, the sample of GPs who contributed to the process cannot be treated as a random selection when generalizing these results.

The questionnaires circulated to PCT members were endorsed by the chairman of the Local Medical Council and promoted by the Designated Lead Doctor and Nurse for Child Protection in each PCT, alongside an information pack about the research. A range of approaches (see, for example Edwards 2007) were used in order to increase the rate of return: inclusion of a 'flyer', individual reminder between two to four weeks after initial receipt of the questionnaire and reminders to the Practice Managers in each surgery after a further month. GPs in both PCT areas received additional reminders early in January 2007 to take account of disrupted work patterns over Christmas and the New Year.

A monetary incentive was initially considered but was replaced by certificates of participation for GPs' development/appraisal portfolios on the recommendation of Steering/Advisory Group members. These were welcomed, and actively sought, by respondents.

Final response rates are given in Table 3 (below). The apparent variation in the numbers of questionnaires by mode of access (Shire County PCT, South London PCT, Training events) is not statistically significant.

Table 3: GP Questionnaire Returns

Area	Questionnaires sent out	Questionnaires returned/completed	GP Response Rate
Shire County PCT	170	31	18%
South London PCT	225	31	14%
Training Events	175	34	19%

Comment on response rates for the GP Questionnaires

McLaughlin (2007) suggests a response rate of 33% is typically to be expected from postal questionnaires and the GPs' response levels is below this. Research into the response rates of GPs to postal questionnaires and surveys notes that these are generally low but suggests that this may be influenced by lack of time, the length of the questionnaire and the institution from which it originates (Templeton et al. 1997, Kaner et al. 1998, Armstrong & Ashworth 2000); these factors were taken into account as far as possible. Personal characteristics, such as age, level of medical qualification and whether someone was involved with postgraduate or undergraduate (medical) training is also known to affect response rate (Stocks and Gunnell 2000) but could not be controlled in this study.

GP interviews

All responding GPs to the questionnaire were invited to participate in a follow-up interview. Thirty interviews were planned, and 26 of the questionnaire respondents indicated that they were prepared to be interviewed. Despite repeated follow up, by both telephone and e-mail, only 14 GPs fulfilled this promise. The remainder cited

other commitments, such as lack of time. In some cases there was no response to all further contacts.

Of the 14, ten interviews arose from the training events with GPs across England and were conducted by telephone for the convenience of these subjects. One GP came from the Shire County PCT, two GPs from the South London PCT, and the remaining GP was one of the four who had originally piloted the questionnaire. The high percentage of those from training events, rather than from the other sources is highly significant (Test 2: $p < 0.004$) and suggests that the views of those interviewed cannot automatically be generalized to those who returned the questionnaires.

These interviews were conducted by the project's researcher and did not appear to indicate any distinction between data from the face-to-face or telephone interviews.

Comment on impact of sample size on interpretation of data

Armstrong and Ashworth (2000) noted that in the interpretation and evaluation of surveys, the non-responders cannot be assumed to hold the same views as those who do respond. For this study, the results are regarded initially as representing the views of the participants and are not expected to be representative of all GPs.

It is likely that while not targeted as a sample, those GPs who responded are more interested and aware of the issues around safeguarding children and child protection than the broader GP population and this should be reflected in participation in training/completion of reports etc. (see Section 5.1); though not generalizable to non-responders, the responses in the study can give an indication of a range of views which is likely to be more informed than an entirely random sample.

The GPs who took part in the interviews were willing to give freely of their time, showed an interest and understanding of their role in safeguarding children, were highly qualified (see Section 5.2, below) and motivated to contribute to the study. These factors need to be taken into account in the evaluation of the research findings.

Nonetheless, the responses of the participants provided a range of examples and views, with individualized models of professional judgement when dealing with difficult situations (see also Section 6.10 for good practice examples).

Key Stakeholders interviews

A total of ten Key Stakeholder interviews were planned with key professionals in the LSCB associated with each PCT and key health personnel responsible for child protection. In order to achieve a full representativeness of these professionals, eight professionals from each LSCB were interviewed. Three additional interviews with representatives from other stakeholder groups to access both minority ethnic and disability view points, were included – leading to a total of 19 interviews. All interviewees had a professional responsibility for, or a direct interest in, safeguarding children with a working knowledge of legislation and policy.

These interviews were semi-structured and lasted for around 45 minutes and conducted jointly, whenever possible, by the principal investigator and the project's researcher. They were recorded and transcribed.

Focus groups

It was intended that the Focus groups would draw from parents and carers based in each PCT area in Patient Participation forums (Patient Advice and Liaison Service) and from a youth group attached to a GP surgery in another London area. The initial response to these approaches suggested that access was subject to gatekeeping (McGee 1999), and one Patient Participation forum advised that these groups were about to be disbanded. The youth group who had originally agreed to participate in the research had also been disbanded before the project was initiated. Thirty other groups were approached on a systematic basis¹⁶ without a corresponding positive response.

The groups that were finally arranged came through personal contacts of the researchers and reflect one of the themes of this study: the value of forging face-to-face personal relationships and networks. Two groups (of parents and young people) were drawn from a South London child-centred charity for young people and families (Jigsaw4u) dealing with loss and trauma. A third focus group was set up from

16 This included: 6 parenting groups, 6 youth clubs, 12 schools, 2 parent/teacher associations and 4 service users groups in the PCTs and the surrounding areas.

members of a local South Korean church within the largest South Korean population outside Korea. Whilst none of these focus groups can be taken to be representative of that minority group, views that are held in common across the separate groups might well be indicative of many 'special groups'.

While it is possible that some participants had had experience of the child protection process, either as a child at risk or as a parent of a child at risk, this was not identified as a requirement. Several members of the focus groups did have experience of being 'looked after' by a Local Authority as children.

The focus groups were semi-structured and lasted for around 45 minutes and led by the project's researcher. They were recorded and transcribed.

The Delphi Panel

The research team set out to create a national Panel from people considered to have acknowledged status, specific knowledge and/or expertise, or a special contribution relevant to safeguarding children issues, for example, from health and social care services, practice, research, education and ethics, and the voluntary sector. A set of criteria was devised to identify areas of expertise sought, and prospective panel members were identified and contacted by the research team. The final composition of the Panel (with the exception of the police) achieved representation from all desired areas (Annex 1) and reflected a wide range of committed individuals, both geographically, and in relation to experience. Forty-seven were approached and 25 agreed to participate, most of whom had direct personal experience or engagement in the safeguarding processes.

The design of the questionnaires used by the Delphi panel was shared across the research team.

Details of the Delphi process are also contained in Annex 1.

4.5 METHODS OF ANALYSIS

The separate components of the study provided both quantitative and qualitative data. The primary approach to analysis was qualitative using open coding (Strauss & Corbin 1990) and thematic analysis (Miles and Huberman, 1994) based initially on

existing policy and guidance (Section 1), and the literature study (Section 2). This was informed, where relevant, by evidence from early rounds of the Delphi panel. This provided a common framework for integration of the separate strands of the research (See Annex 3).

Analysis of the returns from the Delphi panel was non-interpretive as far as possible and conducted by an independent researcher. The processing in this case, both between rounds and in deriving final consensus statements, was almost exclusively quantitative.

Where the consensus view of the Delphi panel concurs with the results from other approaches, particularly those from either the GP questionnaires or the GP interviews, this was expected to indicate a strong correspondence - both between methods of coding (non-interpreted coding by a researcher outside the fields of child protection and GP Practice versus open coding by a social worker with experience in child protection) and between professional groups (a wide range of professional groups versus those engaged in, or directly related to, GP practice).

The use of four vignettes for the Delphi panel, and similar scenarios for the focus groups and the GP interviews provided a useful basis for establishing commonality in the use of terms across the different methods and responses.

It should be noted, in particular, that the use of 'GPs' that occurs in any of the quotations that are included below must be interpreted carefully within the context used by the subject. Where stakeholders refer to 'GPs' from a specific PCT, this normally refers to all GPs (or a typical GP) within that PCT. For service users within the Focus Groups it is likely to refer to the GPs that the service user has known personally, and in the Delphi panel analysis it is used either in the context of how GPs will typically behave or how they should behave. Within the analysis, the reference for this term should be clear.

Quantitative analysis

Quantitative analysis was used, where appropriate, in order to determine independence/non-independence of relationships, where the sample is sufficiently large to do so (e.g. with the coded responses to the GP questionnaires). Statistical

analysis in this study parallels the role of statistical analysis as noted by Cook and Campbell in 1979 to identify *subsets of data within the study* where the covariation is non-random (Shadish, Cook and Campbell 2002) – ie the patterns that are considered significantly different in statistical terms from those that would occur under the assumption that covariation was accidental and random. This is the first stage in a four stage process – the remaining stages: internal validity, construct validity and external validity.

Within this context, statistical analysis is used to identify two different aspects of the data that has been collected: firstly, patterns that indicate non-randomness in the selection of subjects based on data that is available from external sources and secondly, patterns within the data that is collected within the study.

Four tests were used on:

1. The distribution of children on the child protection register between the two PCTs
2. The subset of GPs who were interviewed
3. Within the responses to the questionnaires, the level of response by GPs to parental factors (Section 5.1)
4. Within the responses to the questionnaires, the level of response by GPs to factors related to the presentation of the child (Section 5.1)

Specific details are provided in Annex 2.

SECTION 5: FINDINGS ACROSS THE METHODS IN THE STUDY

The Findings section will give a brief overview of the purpose of each method and present the analysis of the findings, identifying the categories and themes that emerged. It will start with the GP questionnaires and interviews, followed by the interviews with Key Stakeholders, and the findings from the Focus Groups and the Delphi technique. A full integrated discussion of the findings across the methods is presented in Section 6.

5.1 ANALYSIS OF GP QUESTIONNAIRES

Questionnaires were sent to all the GPs in the two PCT areas and were also distributed at six GP training events. A total of 96 GPs returned the questionnaire, of which 31 came from the Shire County PCT, 31 from the South London PCT and 34 from GPs attending targeted training events between November 2006 and January 2007.

The Questionnaire (Appendix 1, Document 2) was designed to gain data about the GPs, their knowledge of the indicators of abuse and the child protection process, their participation in training and case conferences and the conflicts of interest arising from their role in safeguarding children.

Profile of GPs responding to Questionnaires

50 of the GPs were male and 46 female. Almost two thirds of the GPs were White British with Asian being the predominant minority group (See Tables 4 and 5, below). Both gender and ethnicity responses showed distinct variation between the different PCTS whilst the training events reflect an average between the two sample PCTS.

GPs reported a range of special interests within general practice, with nine citing child protection, four paediatrics, three obstetrics and one child mental health as areas of specific interest. The respondents varied in their years of experience as a GP, as shown in Table 6 below.

Table 4: Completed questionnaires and gender of respondents (n = 96)

Area	Completed Questionnaires	Gender	
		Male	Female
Shire County PCT	31	12	19
South London PCT	31	21	10
Training Events	34	17	17
<i>totals</i>	<i>96</i>	<i>50</i>	<i>46</i>

Table 5: Ethnicity of GPs (n = 96)

Area	White British	Other		<i>n/r</i> *
Shire County PCT	28	1 - Asian	1 - Chinese	<i>1</i>
South London PCT	15	11 – Asian 1 - Caribbean	2 - Indian 2 - Black African	
Training Events	22	1 - White Other 7 - Asian	2 - Indian 2 - Other Black	
<i>totals</i>	<i>65</i>	<i>30</i>		<i>1</i>

* no response

Table 6: Years of experience as a GP (n = 96)

Area	< 5 yrs.	5-10 yrs.	11-20 yrs.	21-30 yrs.	31+ yrs.
Shire County PCT	2	7	15	2	5
South London PCT	4	6	10	10	1
Training Events	9	4	8	5	8
<i>totals</i>	<i>15</i>	<i>17</i>	<i>33</i>	<i>17</i>	<i>14</i>

The size of the practices range from one single-handed Asian GP in the South London PCT to a practice of 15 GPs in the Shire PCT (see Table 7).

Table 7: Size of GP practice: number of GPs in each practice (n = 96)

Area	1	2	3	4	5	6	7	8	9	10	> 10	<i>n/r</i>
Shire County PCT	0	0	1	1	3	3	9	4	5	1	3	<i>1</i>
South London PCT	1	4	3	2	2	3	2	6	1	5	1	<i>1</i>
Training Events	0	2	4	5	3	1	3	0	5	6	2	<i>3</i>

GP awareness of indicators of child abuse and neglect

GPs were asked to consider a range of parental and child indicators, which would cause them to be concerned about the safety of their child and to indicate whether this would prompt further intervention. In relation to their perceived ability to identify issues of concern, five GPs expressed anxiety. Almost all (93) responded by rating each of the potential risk factors; three GPs commented that their judgement on safety concerns and intervention would depend on the exact nature of the problem.

Parental Difficulties as Indicators

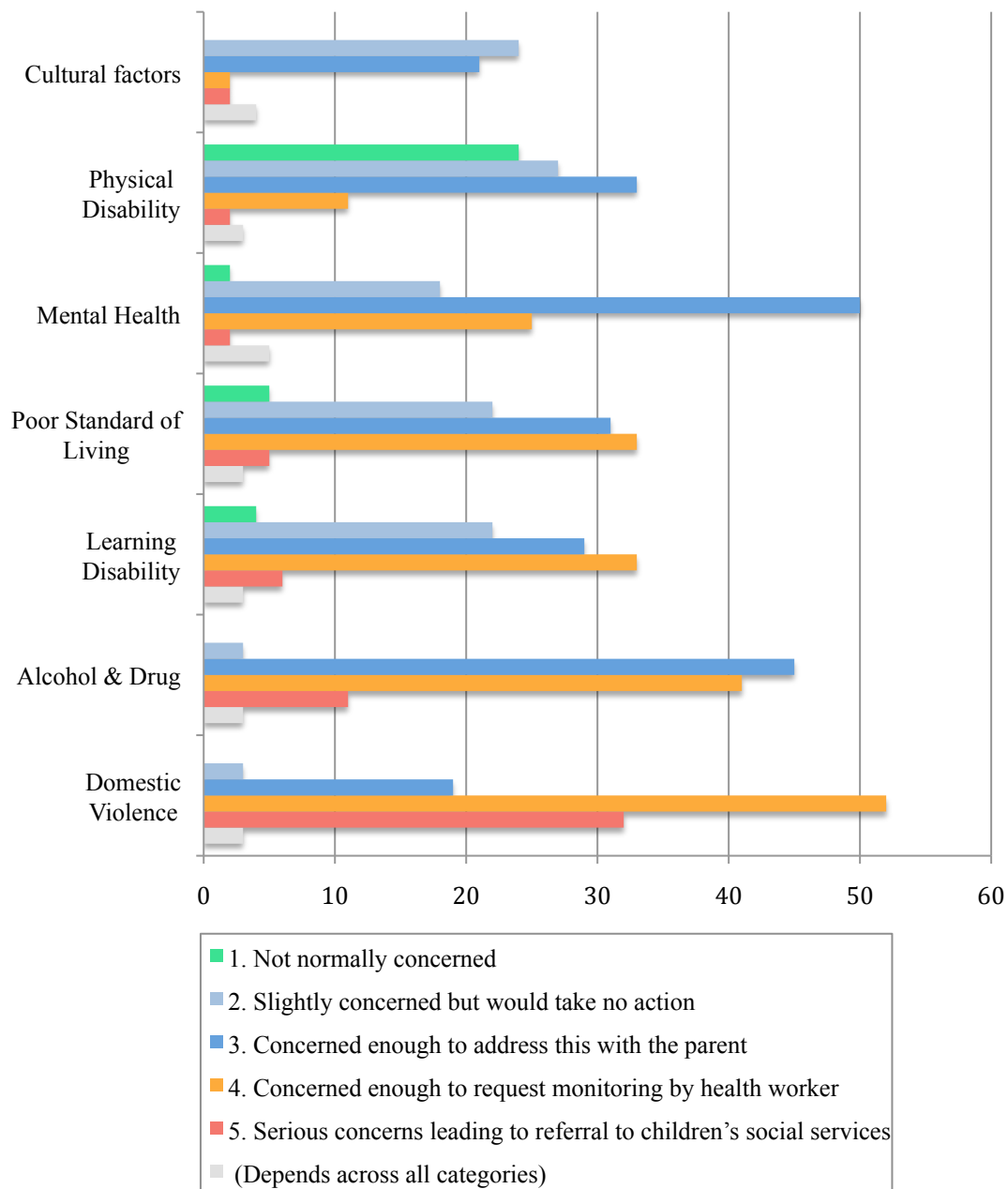
Table 8 presents the range of levels of concern about parental difficulties and their effect on child safety, including health, social and cultural factors, sorted to reflect where increased use of referral to other professionals would be taken. “Cultural factors” was presented as one of the relevant categories for consideration, to allow GPs to identify any aspects of difference (such as ethnicity, diversity, language, background) affecting their levels of concerns, e.g. in child-rearing practices (Webb et al 2002, Chand and Thorburn 2006). This might relate to the parent’s background or differences between the GP and patient. In Table 8 referral to both health workers and children’s social care services increases systematically. There is a significant variation amongst responding GPs in the relationship between the levels of concern across the categories (Test 3: $p \approx 0$).

Just over half the GPs (49/96) indicated that they were concerned enough about mental health problems to address them with parents, with a further quarter requesting a health worker to monitor the situation. While the health visitor was the most likely person the GP would refer to, the term health worker was used, as GPs have a variety of other health care professionals within primary care practice to draw on, such as midwives, practice nurses or community psychiatric nurses.

Drug and alcohol abuse was identified as a concern indicator that 45 GPs would address themselves and 41 would refer on to their health visitors. In cases of domestic violence, 52 GPs were more likely to refer on to a health worker and 32 GPs would refer direct to children’s social care services. 29 GPs were concerned enough about parents with a learning disability to address this with the parents, and just over a third (33) asked the health worker to monitor the family. Apart from domestic violence,

and to a lesser extent alcohol and drug abuse, where 11 GPs would refer to children’s social care services, GPs in the study indicated their preference for referral to health workers, or, in the case of cultural factors and physical disability, to address their concerns directly to the parents in the first instance, if they had any.

Table 8: Level of GP concern about effect of parental difficulties on safety of child (n = 93/96)



The responses showed a slight difference between white British GPs (65) and GPs from other minority ethnic groups (30). GPs from other minority ethnic groups were

much less likely to be concerned enough about mental health issues to address these with the parent, but were more likely to do so with parents with a learning disability. These GPs also appeared less likely to request monitoring by the health worker for all parental indicators, but would be more likely to contact children's social care services.

Child Presentation as Indicators

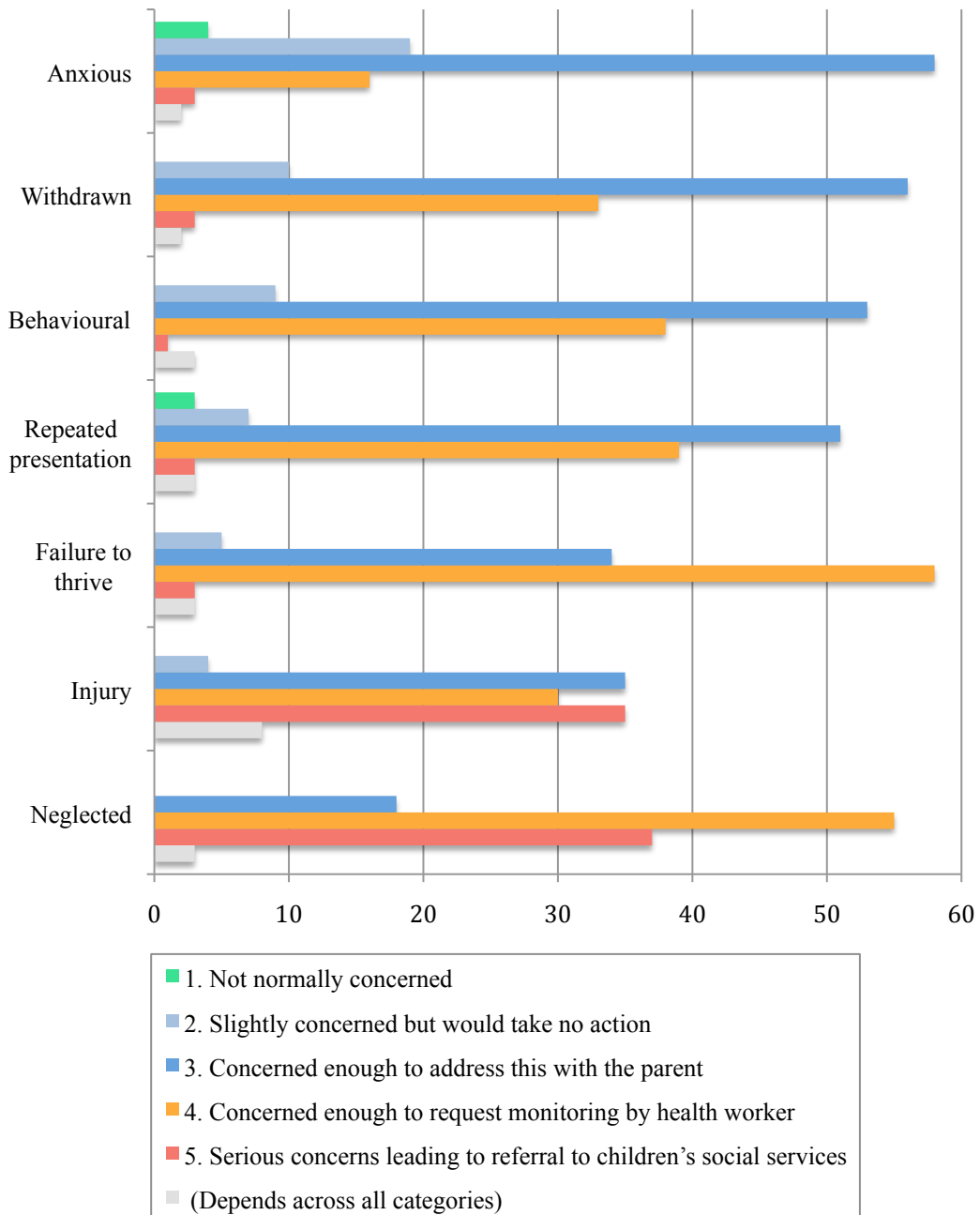
Table 9, below, presents the GP's level of concern when considering the presentation of the child as an indicator of the child's safety and wellbeing. The table is again sorted to reflect increasing use of referral to other professionals. There is a significant variation in the relationship between the levels of concern across the categories amongst responding GPs. (Test 4: $p \approx 0$).

In this table, referral to children's social care services remains low, except in cases of injury and neglect where there is a marked increase. Where they had concerns about neglect, 55 GPs would request monitoring by a health worker and 38 would refer directly to children's social care services. In the case of an injury to the child, 35 would refer to children's social care services and 30 would involve a health worker. Although the same overall level of referral occurs for failure to thrive, there is a marked decrease in referral outside health services (3 to children's social care services, 58 to a health worker).

Over half the GPs would be concerned enough to address with the parent issues of anxious (58) and withdrawn (56) presentation, behavioural problems (54) and repeated presentation at the surgery (51). In the case of an injury to the child, only 35 would address this themselves with the parent.

GPs from other minority ethnic groups were more likely than white British GPs to address with the parent concerns about anxiety, injury, failure to thrive and repeated presentation at surgery. 55 GPs (37 White British, 18 other minority ethnic groups) would be concerned enough about neglect to request monitoring by a health worker. 18 White British GPs and 11 other minority ethnic group GPs would refer to the health worker, where they were concerned about an injury. Other minority ethnic group GPs were slightly less likely to request health worker monitoring or refer to children's social care services. There is no evidence of significant variation on these factors according to the ethnicity of the GP.

Table 9: Level of concern about child presentation (n = 93/96)



GP participation in child protection training

GPs were asked if they had attended child protection training in a multi-agency or health forum, or both, since 2003 (Table 10, below). This year was chosen as this corresponded to the Laming's specific recommendations about training (2003):

Recommendation 14 states that professional training bodies should demonstrate within 2 years that effective joint working between each of these professional groups features in their national training programmes (paragraph 17.114).

Recommendation 15 states that within 6 months, the newly created LSCBs should be required to ensure training on an inter-agency basis is provided, and staff working in the relevant agencies should be required to demonstrate that their practice with respect to inter-agency working is up to date, by successfully completing appropriate training courses (paragraph 17.114).

Table 10: GP participation in child protection training since 2003 (n = 96)

Area	No	Yes	Multi-agency	Restricted to Health professionals?	n/a*
Shire County PCT	18	12	6	9	1
South London PCT	13	18	8	11	
Training events	10	24	14	13	
<i>totals</i>	<i>41</i>	<i>54</i>	<i>28</i>	<i>33</i>	<i>1</i>

* not applicable

From the GPs with between five and 20 years experience (50), 55% had undergone training, with this figure dipping to around 40% for GPs with over twenty years experience (31). Slightly more GPs had received training within a health setting, 12 had undergone both ‘health professionals only’ and ‘multi-professional’ training and three received their training in neither a health nor multi professional forum. All but two doctors with less than five years experience had received training since 2003, (13) reflecting the requirement of the GP Registrar training scheme. Overall, more than half (54) of the GPs had undergone some form of child protection training.

GP Response to Child Protection Concerns

Who to contact

All the GPs were aware of the child protection procedures and almost all of them (84) would consult with children’s social care services when faced with child protection concerns. For just over half of the GPs (50), children’s social care services were not

the first port of call, instead preferring advice and support from a range of health colleagues (see Table 11). Over half of all the GPs stated they would share their concerns with the health visitor. Just over half of the GPs in the South London and training sample named a paediatrician as someone they would contact, whereas in the Shire County only five GPs included the paediatrician as someone they would consult.

Nine GPs said they would contact the school nurse if they had concerns about a child and seven of the GP questionnaires identified the “lead”* child protection nurse as someone they might contact (“lead”* was the term used by participants, rather than ‘named’ or ‘designated’).

Table 11: Range of professionals that GPs may consult when faced with child protection concerns (n = 96)

Professional	Shire County PCT	South London PCT	Training Events	Total
Social Services Department	27	25	32	84
Health Visitor	17	12	20	49
Colleagues	12	15	19	46
Paediatricians	9	14	23	46
Police	8	4	11	23
Child Protection Guidance	7	7	5	19
“Lead”* Doctor	4	6	6	16
Hospital-Admission	4	5	5	14
Primary Care Staff	4	5	3	12
School Nurse	2	4	3	9
School	1	5	3	9
“Lead”* Child protection Nurse	3	2	2	7
Medical D.U	1	0	2	3

GP relationship with health visitor and Primary Care Team to safeguard children

Over two thirds of the GPs (67) said they would refer the family to the health visitor, if they were concerned that a child may be a risk of significant harm. If they were

making a referral to children’s social care services, 57 GPs indicated that they would also involve the health visitor. It was clear that the GPs regarded the health visitor as the most significant health care professional where there were concerns about children.

Managing the relationship with the parents

Just under half (43/96) indicated that the most important concern for them was about their relationship with the parents and the conflict of interest that could arise, in particular around confidentiality and information sharing. Ten GPs reported that they had no problems with the procedures.

Problems for GPs with child protection procedures

GPs were asked if the child protection procedures raised any problems for them and whether they felt the guidelines had ever proved inadequate or counter-productive. While 65 GPs felt the child protection procedures were adequate, 25 GPs had found that they had proved inadequate or counter productive (Table 12).

Table 12: Effectiveness of Child Protection procedures (n = 95/96)

Question	Yes	No	Other
Have you ever been in situations where child protection procedures were inadequate or counter productive?	25	65	n/r 3 n/a 2

Ten GPs expressed concern about the effect of child protection procedures, which they observed could do more harm than good at times:

“Distrust of a system which seems to assume guilt (of a parent usually) rather than innocence before the evidence is complete. This may sometimes be in the best interest of the child, is more often not.” TGP F2

GP relationship with children’s social care services

The second most important concern for GPs (26) centred on the procedure of referral to children’s social care services and their subsequent response. Half of these GPs (13) stated that it was difficult to make contact with children’s social care services to make a referral. Three GPs from the Shire County and training groups reported that

referrals had to be made to a central contact point, rather than direct to the team dealing with child protection.

Sixteen GPs lacked confidence in the response of children's social care services and four commented more widely on a poor inter-agency response to child protection concerns. Around a quarter (23) of the GPs were critical of the role of children's social care services and indicated that this impacted on their response when dealing with child welfare issues. One GP stated it was:

"Less time consuming and emotionally easier not to refer a child particularly if case is not clear cut." SLGP 175

GPs acknowledged the complexities of decision making for themselves and others in the professional network, and one GP noted the dilemma as follows:

"Knowledge that the process of referral to the social services department is not ideal and that can sometimes increase the harm to the whole family. Concern that if suspicion is wrong then more harm is caused but ignoring a correct concern will undoubtedly increase risk." TGP B1

Participation in child protection case conferences

During the previous year, less than half of the GPs (44)¹⁷ had been invited to attend a child protection case conference (Table 13, above). The GP had written a report in 31 of these cases but attendance was low (only nine GPs attended a case conference).

In three cases the GP had both attended and provided a report, and in a further 11 cases the GP had neither provided a report nor attended the case conference.

Key reasons highlighted for non-attendance were: conferences were scheduled at inconvenient times often within surgery hours; venues were too far away with poor parking facilities; the time involved; and GPs were given very short notice. Ten GPs indicated that they had little to contribute and often the issues were already known to health visitors and to other professionals who saw more of the family. Only one GP linked their non-attendance to both time and remuneration.

¹⁷ including 1 'unclear'

Table 13: GP involvement in child protection case conferences (n = 43/96)

Shire County PCT	Provided Report:			South London PCT	Provided Report:		
	Yes	No			Yes	No	
Attended: Yes	2	1	3	Attended: Yes	1	0	1
No	4	5	9	No	11	3	14
<i>Totals</i>	6	6	12	<i>Totals</i>	12	3	15

Training Events	Provided Report		
	Yes	No	
Attended: Yes	4	1	5
No	9	3	12
<i>Totals</i>	13	4	17

Tensions and conflicts of interest for GPs when dealing with safeguarding issues

Time

A third of GPs (33) cited time as a factor when they were faced with a child at risk within a 10 minute consultation slot, noting the time it takes to complete a full history and examination, and then to contact and refer to the appropriate agencies. However, GPs indicated that when they identified possible child abuse, they viewed it as a priority to ensure that appropriate action was taken. They would extend the consultation time to deal with this, but noted that it could disrupt the whole surgery.

The doctor/patient relationship

90 GPs (the majority) reflected in their responses the importance of maintaining a good relationship with their patients, and around a third (30) highlighted the difficulties of addressing concerns about a child's welfare with the parents. This included a fear of alienating parents, parents being abusive and aggressive, and:

“Raising unpleasant issues, confidentiality and consent issues.” TGPB 1

Ten GPs specifically identified a conflict of interest between meeting the needs/wishes of the parent and the needs of the child, both of whom were patients. None of the respondents to the questionnaire made any comment about their relationship with the child.

Information sharing – confidentiality and consent

The GP questionnaires asked GPs whether requests for information raised any dilemmas for them and how often (Tables 14a and b).

Table 14a – Information Sharing and confidentiality (n = 96)

Question	Yes	No	<i>other</i>
If social services department have requested information about a child subject to a risk assessment S47, did you provide this?	58	7	<i>n/r</i> 9 <i>n/a</i> 22
In terms of confidentiality, did this request cause you any dilemmas?		22	<i>n/r</i> 12 <i>n/a</i> ¹ 19
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?	20	55	<i>n/r</i> 19 <i>n/a</i> 2

Table 14b – Information Sharing and confidentiality (n = 96)

	0	1-3	4-6	7-10	> 10	<i>other</i>
How often in the last 12months have you experienced a dilemma in terms of confidentiality?	55	35	2	0	0	<i>n/r</i> 19 <i>n/a</i> 2

Just under half of the GPs (47) indicated that confidentiality was a constraint when dealing with a child at risk. GPs were concerned that seeking consent to share information could have a detrimental effect on their ongoing relationship with the parent/family. Around a quarter of the GPs stated they had no problem sharing information, if it was in the interests of a child’s welfare or they considered it was ‘proportionate’ to the issue and on a need to know basis.

“Confidentiality can be breached but only with good reason. Is the reason under question good enough?” SLGP 358

¹ including 1 ‘cannot remember’

Eight GPs commented on the extent and nature of the information to be provided, and three noted the need for consent from third parties.

Four felt the bureaucracy around making a referral - which required the completion of a lengthy form - militated against information sharing. Three GPs stated that requests for information about patients were not done in a professional way. This was often by phone, with the expectation of an instant response, and it was unclear if the patient's consent had been given. GPs stated that they needed to know the context of the request and why the information was required, to enable a judgment to be made as to whether it was proportionate to breach confidentiality. One GP reported an experience where children's social care services had not respected confidentiality. Ten GPs were also concerned about the implications of sharing information, when the concerns turned out to be wrong.

GPs were asked how often in the last twelve months they had experienced a dilemma in terms of confidentiality and information sharing with regard to safeguarding children. 55 GPs said they had never experienced any dilemmas, 35 reported that they had experienced between one and three dilemmas, three had experienced between four and six dilemmas and one had experienced more than ten dilemmas regarding confidentiality.

The questionnaire asked GPs if they could 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. 55 GPs could not think of a specific example, 21 GPs did not reply to this, but 20 indicated that they could think of examples, with 8 of these describing particular situations. These focused on the difficulty of managing confidentiality and the relationship with the parents, and specific concerns where sexual abuse was suspected. Two GPs commented on the difficulty of managing allegations between parents where the relationship between the parents had broken down. Three GPs expressed concern about possibly placing the child at further risk, if the parents reacted badly to the GP making a referral to children's social care services.

"I think most likely with domestic violence, mental health issues and alcohol where I am not sure I am in a position to assess the effect in children well enough and have to judge whether working with the parents and supporting them safeguards children more than referring on." TGB 4

Two GPs stated that they felt the response of children's social care services had made the situation worse for the child.

Decision making

The most significant factor reported by GPs about the difficulties experienced in coming to decisions about safeguarding children was their concern to manage and maintain their relationship with the parents. This encompassed issues about confidentiality, consent and conflicts of interest. 15 GPs said it was difficult to decide on the threshold for the involvement of others and feared making the wrong diagnosis of child abuse. Ten GPs lacked confidence in their assessment of risk, and three felt it was difficult to get advice without making a referral.

“Essentially I don't have a working relationship with the police or social services. There is no room for informal discussion about a situation. All I need is to feel uncomfortable about a situation and they'll 'take off' – sometimes leaving the debris of a family for me to clear up.” SCGP 99

14 GPs stated their decision making was influenced by the response of children's social care services, and views tended to be polarised between a perspective of lack of action and one of over reaction.

“...social workers seem reluctant to get involved. ... (social services departments) seem not to take concerns seriously.” SCGP 97

“...concern re: 'setting off' a chain of events that may be stressful for the family (especially if unfounded).” SCGP 43

A subset (14) of the (96) GPs responding to Questionnaires were interviewed and the findings from these interviews are presented in the next section.

5.2 ANALYSIS OF GP INTERVIEWS

The interviews were designed to explore in more depth the GP responses in the questionnaire and to gain an understanding of the dilemmas and conflicts they experienced, in relation to their role in safeguarding children.

Profile of GPs who were interviewed

Of the 14 GPs interviewed, 11 were white British, one white other European, one of mixed race and one Asian (Table 15). Seven of these GPs held or had held either the practice lead or senior area lead responsibilities for child protection. Ten of the GPs interviewed were from the training events (widely geographically spread from Newcastle to Cornwall), one was from the Shire County PCT, two from the South London PCT, and a pilot interview was completed with a GP from a second London PCT.

Table 15: Completed interviews, ethnicity and gender of respondents (n = 14)

Area	Number	Ethnicity	Gender	
			Male	Female
Shire County PCT	1	White British		1
South London PCT	2	White British	1	1
Training Events	10	7 White British 1 White European 1 Asian, 1 mixed race	3	7
Pilot	1	White European		1

Tables 16, 17 and 18 present the range of GP experience, size of practice in which they work and their special interests.

Table 16: Years of experience as a GP (n = 14)

Area	< 5 years	5-10 years	11-20 years	21-30 years	years > 30
Shire County PCT			2		
South London PCT			1		
Training Events	3		3	3	1
Pilot					1

Table 17: Size of GP practice: numbers of GPs in each practice (n = 14)

Area	1	2	3	4	5	6	7	8	9	10	11
Shire County PCT							1				
South London PCT		1		1							
Training Events		1	1	2	1				2	2	1
Pilot			1								

Table 18: Special Interests of GPs (n = 14)

Area	Special interests of GPs who were interviewed
Shire County PCT	1 - practice lead for child protection
South London PCT	1 - diabetes 1 - n/r
Training Events	3 - named GP child protection (1 - also mental health) 1 - child protection 1 - paediatrics 1 - child protection/paediatrics 1 - child mental health, 1 - professional representative 2 - n/r
Pilot	1 - n/r

The significance of the GP role in safeguarding children

GPs who were interviewed were asked how significant they felt the GP was to safeguarding children and child protection. Nine responding GPs felt they were very significant, as they were a point of contact where they could see the interaction between parent and child, recognise problems and offer some oversight. One GP stated that the GP was the ‘gatekeeper’, as he would get all the letters about the health needs of the family, and the practice could put the pieces of the jigsaw together. 12 of the GPs interviewed had worked in the same practice for many years in areas with a relatively stable population, where they were often the GP for both the nuclear and extended family. They felt families trusted them.

“Because we’re the service where anybody can walk in through the door... we’re not in any way a vetted service, anybody can say anything to us at anytime can’t they?” IGP

Two GPs reported that patients would often disclose child welfare concerns to them, rather than go to children's social care services or other agencies.

Four GPs were less certain about the significance of the GP in safeguarding children:

"I think it's much more significant than the average GP will let it be... I think the average GP doesn't have as big an interest in children as in some other areas of medicine." IGP G

Three GPs felt that the move towards the management of chronic disease in adults had led GPs to neglect their family role, and that there was a lack of emphasis in the new GP contract on child health and child protection. One stated that GPs had been marginalized in terms of antenatal care and this had been where GPs would develop relationships with parents, who would then bring their children to see the GP in the years to follow.

While nine GPs felt that they, or the primary health team, knew their families well, five GPs were less sure. Larger practices, more part time GPs and other options for care, such as walk in health centres, were cited as reasons why GPs may not know families well. Three made the distinction between the GP knowing the parents and knowing the child, stating that the current practice of screening and surveillance of children goes against knowing families. It was felt that while parents may see the same GP for long term conditions, children were likely to be taken to the surgery for acute conditions and would tend to see whichever GP is available. GP records were likely to hold a great deal of information on parental issues, rather than on the children, and two GPs suggested it was the school who would know the children best.

"I don't think we're the main agency for the welfare of children, no...I think the schools are...because they see the children every day and they know if they're not there." IGP N

One GP commented that more mobile families were unlikely to be known to the GP, yet these children may be in need of more support and surveillance.

GPs were unsure what expectations other agencies held about their role. Five GPs felt that other agencies did not understand the pressures they worked under and the fact

that they tried to keep their response to children within a medical model. They felt their role was limited.

“...the important thing to do for the GP is to be able to pick up, is there a problem here? And if there is then it’s actually really beyond the GP’s remit and resources to sort it. It needs to be referred on. And the GP needs to know at the end of the day that when they’ve pressed the button on the computer and the consultation is over, that they have got that problem channelled safely.”

IGP F

Another GP felt their role was to refer to other services that could consider whether the child was at risk and did not feel it was part of their remit to follow this up.

“It fits in our way of working you see because what we do is screening; we don’t make diagnosis very often. It’s about managing the consultation, then you try and make it (the referral)... ask people to come back, but if they don’t, you don’t have any clout to take it further.” IGP N

Two of GPs commented positively on their relationship with both children’s social care services and the police, and five GPs acknowledged the resource constraints on other agencies and services as well as themselves. Five of the GPs who were interviewed articulated the value of networks and inter-agency networks to safeguard children, although the following quotation appears to focus on the existing and positive health networks:

“I think if the GP has a good health visiting team and a good district nursing team and good links with all of those people, then it’s likely that you’re going to be informed and other people will tell you of their concerns and you can tell them. So again you’re not working in isolation hopefully.” IGP F

GP awareness of the issues for children with a disability and from ethnic minorities

The GP interviews sought to establish the GP’s awareness of the special issues around safeguarding children with a disability and children from ethnic minority groups. GPs indicated that they were aware of the increased risks for these groups of children, but only four of them felt they had had experience in these areas. Two GPs said there

were more resources available for disabled children than for children without disabilities, and one said that GPs saw very little of children with a disability, as they tended to be linked into the community paediatric disability team. Another GP said she did have some experience of children with disability, as 40% of children in a local school had special needs. This GP also gave a very positive example of where close working between different professionals had identified and addressed serious child protection issues in a family, where there were quite complex needs.

Two GPs, who had a number of ethnic families within their practice, reported that this had not raised any issues with regard to parenting. One GP felt these families were quite close-knit and supportive, but noted that language difficulties meant that it made it harder to pick up the subtleties of the family dynamics. It was often the family members that acted as interpreters. Another GP had done some research in her area as to why there appeared to be a high number of children from ethnic minorities on their child protection register. She had concluded that these children tended to come from larger, more deprived families than the white British children in the area. She gave an example of a cultural issue where the father felt significant corporal punishment was acceptable.

Only one GP who was interviewed came from an ethnic minority group. She had substantial experience of working with ethnic minority families and saw her role as educating families. She felt that these families were not aware of the rules and it was not that they were neglecting their children; it was because they did not know what to do. She said she used consultations to teach them about things like immunisation, or the need to get a husband to stop smoking when the child suffers with asthma. This GP used the fact that in her culture “*GPs were like God*” to try to empower the mothers to improve the situation for the family, and felt if they trusted her, they would follow her advice.

“Look, it’s not like back home in India or Pakistan, here you need to raise your voice... So I always you know, educate them and make aware of them that there is possibilities, there are guide lines or the help available.” IGP M

GP participation in child protection training

While ten of the GPs interviewed felt in principle multi agency training was valuable, it was not seen as practical for busy GPs to participate in this, and four complained that the training was pitched too low, was not seen as relevant and tended to focus on who to contact, which was likely to change over time anyway. Ten GPs felt that if child protection training was a Quality and Outcomes Framework (QOF) target, then GPs would be likely to attend. Three GPs were not so sure. One felt that GPs would still have to prioritise their activities:

“...you can't create time that doesn't exist.” IGP F

Another GP felt multi-agency training would help GPs understand the role of other professionals, but suggested that as GPs do not come across child protection that often, they would develop relationships as they needed them. A third GP stated that a QOF target was not a simple answer, as GPs needed too be more reflective about their practice:

“I think that people can easily go through it... and actually doctors need to be much more reflective about what they're doing, about the way in which systems work... we need to be at a whole deeper level altogether, doing significant events but really reflecting on them with the whole team, at a much deeper level.” IGP L

Four GPs felt it was of more value to have training within the practice and saw the PCT as having a role in providing this. They suggested that the practice lead GP could attend other training with a view to cascading it back at the surgery.

GP response to child protection concerns

Who to contact

Nine of the 14 GPs who were interviewed said they would consult with health colleagues and, in particular the health visitor, when they had concerns about a child's welfare, before making a decision to refer to other agencies. They explained this as feeling comfortable with these colleagues, where they could discuss the situation informally. They also said that talking to health colleagues did not raise issues of confidentiality, as they felt they had implicit patient consent to share with health

colleagues. One GP said he regarded the health visitor as the other major health colleague in child protection.

GP relationship with the health visitor and Primary Care Team to safeguard children

Nine of the GPs interviewed reported that health visitors were not based at the surgery, and six commented on the impact of this on the opportunity for informal face-to-face discussion. Several GPs reported that they had good working relationships and regular meetings with the health visitor. Three GPs said they had very little contact with health visitors, whose numbers were diminishing, and anticipated that the move to geographical, as opposed to surgery, patch areas and children's centres would weaken links further.

One GP stated that the restructuring of Primary Care and the health visitor's role meant health visitors no longer knew their families well and they were losing their expertise with 'normal' families.

"I'm not quite sure how I envisage a future where it's all sort of detached into centres and they don't have that grassroots contact with the families on a more every day basis." IGP G

Three GPs stated that they tried to manage concerns about a child's welfare within the practice and within a health arena, as they felt that children's social care services were unlikely to do anything and this way they could keep control of what was going on.

"I think we try and do a reasonable risk assessment within primary care, because the problem is once you refer it on to somebody else you do, you do feel it's out of your hands, and it's actually much more difficult to track what's going on and you know, I think we need, certainly need to keep a sense of responsibility for that, for that particular anxiety." IGP J

Three GPs noted that parents did not always react well to the idea of referral to children's social care services and were concerned that they would lose contact with families, if they thought the GP was going to refer to children's social care services.

"I do report, but it is difficult...but not at the initial stages and actually I think keeping social services out of it at an early stage was beneficial because the

family closed right up and saying 'We're not having anything to do with social services.'" IGP L

One GP reported that a referral to children's social care services had had extremely bad consequences for the family and for herself, and that she was now very reluctant to make any referrals.

"...because we don't work together, we don't know what the consequences are." IGP N

She said if she were concerned about a child, she would try to contact the health visitor or school nurse, as she saw this as a way of maintaining her relationship with the parents and avoiding any conflict, as the parents would view it as:

"...acceptable for me to phone the school nurse, but if I say I would like to speak to a social worker then your relationship is very difficult." IGP N

This GP then expected that if the health visitor or school nurse was worried, that they would pass on the concerns to children's social care services, but noted that she was unsure if this happened, as she never got any feedback. Although she made referrals to the school nurse, she lacked confidence in their role in safeguarding children

"...the few times I've tried to phone the school nurses and there's no, there's no common ground – it doesn't seem to work" IGP N

Problems for GPs with child protection procedures

Managing the relationship with the parents

The GP's relationship with the parents and the conflict of interest that could arise, in particular around confidentiality and information sharing, was explored further in the interviews. Thirteen of the GPs interviewed indicated that they were clear how they should respond to child protection issues and that they needed to manage the conflicts that may arise.

"Would I think it right not to make that referral because you're afraid of rupturing the relationship with the parents? Never. I would never think that the relationship with the parent was worth preserving at the risk of not reporting. No, I think that would be completely wrong actually." IGP A

Three GPs commented on how issues could be avoided, and one suggested it was easier to give the benefit of the doubt, when things were not clear. One expressed difficulties around case conferences, due to the fact they felt that the GP was an advocate for their patient (the parent). Two stated that the short consultation slot and lack of time for follow up meant that it was possible not to explore issues.

“For most ordinary GPs, I think one of the things that I think stops them getting involved – well, it would stop me getting involved – is that if you don’t look for it, you don’t have to face these dilemmas.” IGP B

GP relationship with children’s social care services

Twelve GPs interviewed expressed concern about the response of children’s social care services to their concerns about the welfare of children. Three commented on the frustration of having to refer through a central contact point and the lack of opportunity to speak to a social worker.

One GP noted the value of discussion:

“It actually, it corresponded with some other information that they’d been given and actually the children were removed. But you know, it often takes lots of people to phone in with that kind of evidence doesn’t it?” IGP L

The response of children’s social care services and the determination of thresholds of intervention were seen as variable, inconsistent, and dependent on the *“amount of workload.”*

One GP commented:

“A lay referral gets treated with more seriousness somehow than a professional referral... we get lots of enquiries, Section 47 enquiries where an allegation’s been made by a parent about something happening at school or at a nursery and so on, and that’s all pursued with great enthusiasm but if a health visitor or a GP makes a referral...” IGP G

GPs commented on the inconsistent response by children’s social care services, who either went in *“all guns blazing”* or did not seem to understand the concerns. One GP noted that GPs like a swift response to referrals, but that child protection is not like that and does not fit into the model of their training.

One GP stated that he had worked quite hard to get the family to accept a referral to children's social care services, but the process had proved a negative experience for them, and he felt this would not make it easy for him to refer in the future.

Three quarters (10) of the GPs interviewed said the lack of feedback was a concern, and two expressed concern that following investigations, social workers did not refer back to the GP for further discussion of the situation, before deciding on "no further action". In one particular situation, a mother had expressed concern about inappropriate play and supervision at an activity centre. Children's social care services had investigated this and concluded there was no cause for concern, without discussing it further with the GP and mother. This GP suggested:

"It's not in the spirit of this Working Together business; it's not in the spirit of it, even though she might have done right according to the book." IGP J

Two GPs said they often learnt of the outcome of referrals from the health visitor or the family under question. Another GP stated that it had been suggested that GPs should be proactive in seeking feedback, but felt this showed a misunderstanding of the GP role.

"We're being told we should be following that up more actively – but I'm sort of thinking, again it's misunderstanding of roles and different agencies. If you did a referral to a consultant paediatrician for advice, you'd automatically expect to have an outpatient letter back. You're referring to social services and you don't get anything back, even if you've been the referrer." IGP B

Eleven GPs noted the lack of communication and trust between GPs and children's social care services:

"One of the issues of trust between the professions, that on the whole general practice doesn't trust social care, and there's very little movement towards trying to improve that". IGP G

Participation in child protection case conferences

Three GPs saw attendance at a case conference as an example of a conflict of interest and a reason as to why GPs did not attend or write reports.

“Patient comes in to see me and I’m, I’m their advocate, I’m trying to do the best I possibly can for them and the child. I think in that role, and then you go into a meeting where you’re potentially taking a child away from the family, there is a huge conflict for GPs in that.” IGP K

Three GPs stated that they felt the GP had a valuable role to play in case conferences. They suggested that if conferences were held at lunchtime, or at a time to suit GPs, then they were more likely to attend. Two of the GPs interviewed raised the difficulty of managing third party information, both on patient records and in report writing for conferences, and identified this as a conflict of interest, especially when the GP was the GP for the whole family and extended members of that family. One was concerned that the disclosure of information to the parent could impact negatively on the child.

Factors relating to conflicts of interest for GPs when dealing with safeguarding children

Time

All 14 of the GPs interviewed stated that time pressures impacted on how they worked, from managing a consultation within a short time span to making choices about which meetings or training they attended. Two GPs outlined a typical day. One full time GP held two three hour surgeries a day, one from 8.30 – 11.30am and a second from 3.30 – 6.30pm. In between times, she reported that she had *“a million things to do”* and did not get a proper lunch break. Another part-time GP held one surgery a day, but still found that the demands of meetings, administrative tasks and visits took up the rest of the working day and said she worked around a forty hour week.

The doctor-patient relationship

One GP noted that GPs have a duty of care and confidentiality to all their patients and it was difficult to remain focused on the child as the more vulnerable party. However all the GPs were clear that the needs of the child were paramount,

“...because if I’m concerned about a child, the child is my first issue rather than the confidentiality, so I’m happy to report my issues.” IGP E

GPs gave examples of where they had had to inform parents that they would be making a referral. One GP felt it was often easier than anticipated. Three found that the relationship with the parents broke down at least temporarily, but for others they were able to maintain a rapport.

“...you’ve built your relationship over a long period of time and you may, something may be difficult but you do still do it – it doesn’t fall apart as much as I think people would think it would.” IGP B

Two GPs were aware that some parents would choose to see other GPs, or not attend the surgery where they have had to address issues. Four GPs gave clear examples where they had addressed concerns with the parents and, despite an initial adverse reaction, had been able to maintain or rebuild the relationship over time. Of these cases, one proved to be an unfounded suspicion of sexual abuse, one resulted in the children being removed from the mother, and two involved investigation by children’s social care services with no clear outcome.

“I’ve regained that rapport again since, and that’s part of the art of being a GP is allowing time to elapse. So I have been able to rebuild that relationship with that parent, despite the fact that they did not approve of the action that I took.” IGP G

Information sharing – confidentiality and consent

Four of the GPs interviewed commented on the difficulty of getting information from children’s social care services about their involvement with families and the outcome of any referrals made by the GP. The ‘not knowing’ what had happened raised considerable anxiety for three GPs. The GPs who were interviewed were clear of the principle of confidentiality and how this relates to the safeguarding of children.

“...you owe a duty of care and confidentiality...as set out by the GMC to each and every one of those patients. And if you suspect that a child may be in harm’s way...the child’s interests have to be paramount because they’re probably the most vulnerable person in that situation.” IGP F

One GP stated that in her practice, where they were concerned about repeated failed appointments, they would write to patients and say, if they did not bring their children

into the surgery, they would have no alternative but to make a referral to children's social care services.

Another GP raised an issue about confidentiality principles for patients with HIV/AIDS, where the mother had refused disclosure about her own and the child's medical history and where the child was due for immunisation, which could put it at risk. There was a clear conflict of interest in this case, which had led to conflicting advice from various medical bodies, and was only resolved when a non-medical member of staff inadvertently breached confidentiality and gave the doctor the information required. This GP posed the following question:

"Well, all the information that we have coming out from every other authority to do with children is that the child's health is paramount... So why is it just because a parent has HIV that the child's health is not paramount?" IGP H

Two GPs described how they placed an indicator of concern on the records of patients who were vulnerable. One GP stated that they had several codes for children, including one for concern about a child not on the register. She felt this needed some standardisation. Two GPs highlighted the confidentiality issues, in cross referencing concerns or written reports on the notes of parents and siblings, and the need to inform patients that something had been included in their notes. One GP suggested that a QOF template for children might be a way of triggering the GP to think about the needs of vulnerable children.

Only two of the GPs were aware of the ContactPoint system (previously known as the Information Sharing Index) planned for implementation by the end of 2009. One felt this would provide little more than demographic information and expressed reservations:

"I know there is going to be a flag attached for people to point out that further information is available... but I think it needs to be managed with great care, you know we need to share information but we do also need to protect confidentiality" IGP G

Decision making

The difficulties of making decisions were discussed further in the GP interviews. One very experienced GP stated:

“There doesn’t seem to be a graduated way of dealing with a problem ... it seems to be an all-or-one model. There doesn’t seem to be a variety of models for a variety of situations.” IGP J

Nine of the GPs gave case examples where they had made a decision to address concerns about a child with the parent and to tell them what action they would be taking. It appeared that having identified an issue of concern, the GP then went on to address this. Their anxiety was around managing the interaction and ongoing relationship with the parent and the response of children’s social care services, which many felt was inconsistent. A further complexity for five of these GPs was the family dynamics and the GP’s potential involvement with other third parties, which could make record keeping and report writing problematic.

Decision making in relation to case scenarios

Twelve of the GPs interviewed were presented with two case scenarios and asked to say how they would manage the situation; two GPs, constrained by time, were unable to participate in this part of the interview. The scenarios were based on the vignettes put to the Delphi panel and similar to the scenarios put to the focus groups.

GP Case Scenario One

‘A young mother from an ethnic minority with two preschool children who presents at the surgery to say she is not coping. She has a history of depression and says she feels like killing herself and that 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.’

Eight of the GPs focused on the mother’s needs first and said they would assess her mental state and consider what help she needed. One GP put the needs of the children first.

“I think one would actually - rather than focus on her – start focusing on the children you know. And trying to assess the risk to the children.” IGP J

Three GPs saw the needs of the mother and child as being *“intertwined”* and one commented:

“...clearly the priority is to do something to safeguard the kids as well as safeguard her life.” IGP H

All of these GPs took the view that they would take some action, despite the mother stating that she did not want any help. They were able to justify overriding her consent. Three felt that the fact she had expressed her feelings meant that she wanted help, and by refusing it, that she was displaying irrational thought processes. Six of the GPs said they would ask their health visitor to get involved, and four said they would contact children’s social care services, if the mother remained resistant to help or did not have family to care for the children. Six GPs commented on the ethnicity of the mother and the fact that this could raise communication difficulties and the need to be aware of cultural issues.

One stated:

“...they do seem to take overdoses and things more. When they say they’ve thought about it, they really have.” IGP I

An Asian GP felt that the mother:

“...being an ethnic minority puts everything into even more risky place, because that, she managed to get the courage to come and speak to me, so I have really you know, I have to make use of that situation.” IGP M

GP Case Scenario Two

‘A 13 year-old girl who presents at the surgery and discloses that she has been having a sexual relationship with a family member for two years and is worried that she is pregnant. She only wants advice about a termination and does not want any other intervention.’

All twelve of the GPs asked to consider this scenario said that they would have to explain to the girl that she could not manage this situation alone and needed the support of a trusted adult. Seven indicated they would consider if the girl was ‘Fraser competent’ (Gillick competent) and of these, four commented that at 13 she was still a child and was therefore not able to make decisions. All the GPs talked about developing a relationship with the girl and separating out the need to establish if she was pregnant, with how to manage the whole situation; they were clear this was abusive and not in the girl’s best interests. Ten of the GPs indicated that they would take their time and probably more than one appointment to resolve the situation. They would discuss the matter with colleagues as to how to proceed. One GP said he would contact the Medical Defence Union for advice.

All of the GPs were clear that they would report the matter to children’s social care services and although they would do their best to persuade the girl to voluntarily disclose, if this was not possible, they would override her consent. One GP commented on the bigger picture:

“...who else is he abusing, who else has he abused, who else is he going to...you owe a duty of care to the wider public as well.” IGP F

The GP responses to the scenario suggested that they were able quickly to weigh up situations and come to clear decisions as to whether to breach confidentiality.

5.3 ANALYSIS OF KEY STAKEHOLDER INTERVIEWS

Nineteen interviews were conducted in all with key professionals in the Local Safeguarding Children Board (LSCB), key health personnel responsible for child protection and key representatives from stakeholder groups. These interviews were designed to obtain data on local multi-agency arrangements and information sharing in each PCT. They also sought the views of Key Stakeholders on the role of the GP in safeguarding children and the conflicts that may arise for them when faced with concerns about a child's welfare (See Appendix 3, Document 2: interview schedule).

Profile of Key Stakeholders

Shire County PCT

A total of eight interviews were conducted in the Shire County PCT, six with members of the LSCB representing health, children's social care services, education, the police and a voluntary agency, and two with lead health professionals. The purpose of the interviews was to explore their understanding of the role of GPs in safeguarding children within the PCT. There were four male and four female participants, all of whom were white British. Although recent reorganisations had meant that some people had been given new job titles and positions, all but one of the Shire County personnel had held key posts for a number of years. Six people had worked within the county for between 13 and 30 years and had a good knowledge of the area and different agencies involved in child protection work.

Seven people worked for statutory agencies and had a very clear remit in terms of their safeguarding responsibilities and participation in the LSCB. The representative of the voluntary agency commented as follows:

"I guess my role is partly to be a thorn in their side... I think part of my job is to remind the Safeguarding Board what a poor job we are doing about prevention, and to try and help the Safeguarding Board to think more about prevention than about the protection jobs that they do." SCKP J

South London PCT

The eight key professionals interviewed were all female and members of the LCSB and represented health, children's social care services, education, the police and a

voluntary agency. One person was black-British and the rest were white-British. Three people had moved into new posts as services had been restructured, but six people had worked within the borough for five years or more. Two people had worked for less than three years, two for around 5 years, three between 9 and 11 years and one had worked for the council for eighteen years. One person commented on the effectiveness of the LSCB, identifying partnership as important:

“I think the partnership, the quality of the partnership arrangements are just essential in terms of good safeguardingI think we’re just very lucky, we have very good partnerships generally in SL and the partnerships around safeguarding are no exception.” SLKP P

Other Key Stakeholders

Three further interviews took place to enable the views of people from ethnic minorities and those caring for children with disability to be represented. One of these was with a female worker from a charity to protect African children from abuse, and the second was with a female employee of the Home Office, who was also a member of South London PCT area LSCB. A third interview was held with a white British mother of a child with a disability.

Views on GP role

Significance of GP

Key Stakeholders were asked how significant they felt the GP role was in safeguarding children. All the key stakeholders were quite clear that GPs had a role to play, using terms such as ‘vital’, ‘critical’, ‘essential’ and ‘hugely’, to describe the GP’s significance.

“...because they are seeing children across the board so they are going to have more of an overview and families might be going to them with concerns that they might not take to a social worker or to someone else, because they see them as more neutral.” SCKP E

“I would be very clear that the GP has a role, but that role is a role in monitoring physical and mental health and well-being and reporting concerns. But beyond that I’m not sure what else a GP can do.” SCKP F

Five of these participants went on to say they felt that GPs have the potential to be significant, but questioned whether they fulfilled this expectation.

“Is it how significant or how potentially significant? There’s a slight difference I think, because in terms of current practise, one might say that they are not necessarily participating as fully as they possibly could for a variety of reasons.” SLKP H

Another noted that GPs might not view their role in the same way as other professionals:

“I think the role of the GP is absolutely essential in safeguarding. What I’m never clear is how the GPs themselves view that, that role.” SLKP P

Five of the Shire County Key Stakeholders were less certain about the significance of the role of the GP. In some case they felt they could be highly significant, whereas in others their involvement was minim

“I think they’ve marginalized themselves to be honest...I think they cut themselves off from it, and as a result become even more removed.” SCKP B

One person while acknowledging GPs had a *“critical child protection role to play”* said:

“I don’t think GPs generally speaking have sufficient knowledge, training about child protection issues to be able to discharge their particular responsibilities as well as they might.” SCKP J

One member of the South London LSCB felt that other professionals who are in regular contact with the family were more important than a GP who only saw families when they initiated contact. A member of the Shire County LSCB reported that when the LSCB had recently asked members if they felt the GP had a significant role in safeguarding children:

“Everyone looked round and said ‘we don’t think so.’” SCKP M

This person then went on to say: *“GPs – they’re not even on our radar”* SCKP M

The two participant stakeholders from ethnic minorities stated that the GP could be highly significant for children who had been brought into the country illegally or under private fostering arrangements. One noted that many of these children do not

attend school, but may on occasions be taken to see a doctor who could be the only professional they ever come into contact with.

“... female genital mutilation or child trafficking ... domestic servitude ... children might not have an opportunity of coming across any other professional (apart from the GP) in the course of their abuse or exploitation or suffering generally speaking.” OKP R

This key stakeholder emphasized the significance of the GP to these children:

“The only time those children might be taken out of their home to see an expert who’d be, at a time when there you know, there’s not all the options, the only other option is to leave them to actually die or actually you know, suffer more significant harm. So the only time when they’re taken to see an expert will be when they’re taken to see a medical doctor.” OKP R

Expectations of GPs

All the participants expected GPs to have knowledge about child abuse, to be able to identify issues and patterns, to follow the procedures to report this and to share information about the child’s situation.

“We expect them to provide a child centred service and be very aware of the vulnerability of children and families and be able to identify and refer children who are in need or at risk.” SLKP G

Thirteen of the 16 LSCB participants were unsure as to whether GPs fulfilled these expectations and explained their reasons, which centred on the competing demands on the GP’s time and the conflicts that can arise when dealing with child protection issues.

“They are meant to be everything to everybody... for us it’s a big bit; to them it’s a little bit of a hundred of other things.” SLKP H

“I think that GPs are in a desperate dilemma, because the system would expect the GP’s job is simply, make a referral and pay no regard to what the other needs are because in a way it’s not the GP’s job. But then I think it probably is the GP’s job to pay regard to the needs of his various patients.”

SCKP J

“I think we’ve learnt to accommodate that GPs are extremely busy and are often hesitant to share information, because if they’ve got the information on the adult as well as the child they, its quite a difficult job deciding what is relevant about the adult’s medical situation or the information...to the protection of the child.” SCKP Q

One member of the SL PCT noted that the expectations on GPs were the same as for any professional working with children, and linked this to the central theme of *Working Together to Safeguard Children* (DH 2006) when she stated:

“Children’s safety is everybody’s responsibility.” SLKP F

GP knowledge and awareness of child protection

Policy context

The Key Stakeholders had a clear understanding of the policy context for safeguarding children, with the Every Child Matters agenda and the development of Children’s Trusts. Few of them had considered how GPs would or should link into this policy of closer collaboration, and one person from the Shire County stated that he felt the LSCB was not thinking laterally enough about the role of children’s centres and GP surgeries. Six participants suggested that the difficulty of engaging GPs and the perspective that GPs were on the periphery of the safeguarding children agenda had meant that there tended to be an acceptance that GPs would not be involved.

A difficulty cited by four people was that the GPs are *“their own entity and do not represent anyone other than themselves”*. However, a medical representative on the Shire County LSCB felt in a multi disciplinary setting:

“...it was very helpful to have a GP voice saying, ‘well actually in general practice, you know we can only do this or we’ve only got this time.’” SCKP L

Two participants thought that GPs should be required to participate more fully in the safeguarding agenda, and the PCT was seen as the body to achieve this.

“...because they won’t come to the table voluntarily, I think they have to be made to, through contracts, through standards, whatever.” SLKP K

Awareness of child abuse and child protection procedures

Around a quarter of the participants felt that GPs' awareness of child abuse is variable. A lead health professional felt that GPs were very able at identifying risk factors but reported that:

"GPs say 'we identify it but we don't kind of do anything with it because nobody else will act.'" SLKP G

An experienced paediatrician stated that GPs tend to think that child protection is related to a child with an injury and questioned a frequent comment by GPs that they hardly ever see child protection cases.

"...actually they're dealing with child protection every single day, every surgery they'll have a parent with a mental health problem or learning disability or substance misuse coming in." SCKP L

The majority of the participants identified factors that they felt impeded the GP's awareness of safeguarding issues, and they were less confident about the GP's knowledge and ability to connect indicators of abuse to the potential safety of the child.

"I would hope that they're able to start looking at patterns of symptoms and I would hope that they would start thinking about the family context, but I think they are kind of trainees in terms of general awareness." SLKP E

The key stakeholder from the charity supporting African children felt that GPs lacked knowledge about belief systems that could place African children at special risk.

"...the medical practitioner might see this as definitely a case of physical abuse, but might not know enough to be able to link that with actual witchcraft abuse." OKP R

She also commented that this lack of knowledge applied to children's social care services as well.

"Certainly social services... most practitioners can't even identify the symptoms of witchcraft abuse. All they see is the physical abuse." OKP R

The fear of being wrong, the difficulty of making a referral and concern about the relationship with the parent, were all factors thought to impact on the GP's actions.

One person also suggested that, where the GP had long standing knowledge of the family and patterns of behaviour, this could lead them to make allowances for standards of care, which would normally not be acceptable. Another person noted that GPs were better at identifying child protection concerns, when they have just had some training.

GP involvement in child protection case conferences

All of the participants noted that GPs rarely attended case conferences, and that there was a resignation and culture that they would not attend. Three people commented that there were a few GPs who always managed to attend, that GPs were more likely to attend the high profile cases and when they did attend, could be very influential. Where GPs did not attend, they were expected to provide a report. Six participants stated that they had seen few reports, and where these had been provided, there was some dissatisfaction about the quality of the information. Two people in the South London PCT area stated that GPs were paid for reports, and they felt that these were provided for this reason.

Participants felt the reason for GP non-attendance at case conferences was because most conferences were held during surgery hours, lack of time and the fact that conferences could last several hours, as well as GPs feeling they had no information to contribute. Three people mentioned the issue of financial remuneration for attendance. One stated the GPs' view was that they would not attend

“unless you're paying me for it or paying for a locum.” SCKP O

GPs' knowledge of families

All but three of the participants felt that GPs knew their families well. The Shire County participants felt they had a very stable population, both in terms of patients and GPs. In both PCTs, GPs were thought to have known their patients and the wider extended families for a long time and, one South London person noted, *“patients never get discharged from their GP”*, though this may not always be the case. Eight people commented on the fact that while families and children may be seen infrequently by their GP, they will be seen over long periods of time. It was also noted that GPs were likely to hold a huge amount of information about adult health, and parents with problems (that may be indicators of risk to children such as domestic

abuse, mental health and drug abuse) are likely to visit their GP surgery more frequently. As one person stated:

“I think the key for me is they’re able to put the pieces of the jigsaw together.”

SLKP E

The three participants who were less sure about how well the GP knew their families pointed to the short consultation times and the changing structures of GP services, where patients tended to be seen by different GPs. However, one person commented, that even if the GP did not know the family, then other practice staff would probably have knowledge about them. Another person pointed out that while GPs may know the families, they may only have very brief contact with the child two or three times a year. It was also noted that more mobile populations, asylum seekers, trafficked children and recently arrived immigrants would not be well known to the GP.

The mother of a child with disability had been registered with the same GP, since the birth of her daughter some seventeen years ago. She had subsequently had three more children but stated that the GP did not know her or her family, saying *“you tend to see who is available”* and there is no continuity. Her experience was that the GP would just deal with whatever ailment a patient presented and nothing else.

“My GP is rarely concerned with what else was going on or how the family is, there is no general chit chat or asking ‘how have you been?’” OKP S

This extended to not apparently checking out who would care for the children, when the mother (a single parent) was required to go into hospital, though with four children one of whom had a disability, this would have a major impact on the family.

GP awareness of issues regarding ethnicity and culture

The 6 Shire County Key Stakeholders reported that they had little experience to draw on, with regard to issues for children from ethnic minorities and one commented

“...it’s a nice place and for most GPs they probably don’t face it.” SCKP O

The percentage of the population from an ethnic minority group was higher in the South London area. One participant from this area felt that GPs were not good with diversity and another suggested that:

"I think ethnicity is slightly more difficult (than disability) 'cos it's seen as a social issue. I wouldn't think they would use interpreters very much." SLKP G

One Key Stakeholder noted that, where the GP comes from the same minority group as the family, they would be:

"...ideally positioned to pick up on...issues around false marriage, female genital mutilations, all those kinds of things" SLKP P

Two Key Stakeholders felt shared ethnicity may not be a protective factor for the children, as the GP may be caught up in the cultural issues and choose not to *"tune in."*

Five participants felt that GPs were not sure how to deal with cultural differences in parenting, and one noted that certain levels of punishment were sometimes used as a defence as being acceptable in certain cultures.

One person from an ethnic minority group commented on the GP's awareness of the needs of children from ethnic minorities as follows:

"There's double standards when it comes to children under the immigration hat. You know, the population who are born here, everyone jumps....but when it comes to children who are coming here through whatever means into the country,the system needs to be able to give these children as much care and protection as children of the indigenous population." OKP C

Another person stated:

"The whole child protection system is out of its depth when it comes to children from ethnic minorities, I don't think that there's a good interaction with an understanding of culture and family environment." SCKP J

One participant was concerned about the implications of the GPs' lack of awareness of the specific issues for black children and the fact it is less easy to spot bruising.

"...if a child is being abused physically in that sense (beaten), it might not be apparent to a GP who is not familiar with black children in that sense, to be able to quickly identify that this mark I'm seeing on this child's body is deliberately, is being caused deliberately". OKP R

The link between witchcraft and child abuse was highlighted by the person from the African Charity and was seen as an area where the GP might have a role in identifying the signs, but often misses them. She gave the example of a malnourished child, where:

“...they don’t see that starving the child, is making the child to fast... And that’s generic in cases of witchcraft abuse. The fasting element is you know, so the child fasts – that can help the child, to tear out the devil within that child.”

OKP R

The comments by the Key Stakeholders highlight the complexity of a multi-cultural society and a multi-cultural profession, and the difficulties that this raises for all professionals as well as GPs.

GP awareness of issues regarding disability

The Key Stakeholder professionals felt knowledge around the special safeguarding issues for children with disability was variable. One felt that most GPs were comfortable with disability, as there was a clear medical model applied to addressing issues. Another person said that there had been significant training around disability and that children with a disability did not use their GP very much, as they tended to be seen in schools, and GP practices were not ‘disabled’- child-friendly.

One person expressed some concerns about the GP’s approach to children with a disability:

“Rather than being something about the child’s wishes and feelings and needs for protection, disabilities very quickly becomes about which resource.”

SLKP K

The mother with a child with a disability felt that GPs had no real awareness of the needs of children with disabilities or their parents. She also doubted that GPs would pick up on parental problems, which might impact on the quality of care they could provide. She felt this limited understanding extended to the whole GP practice, with receptionists often finding it difficult to accommodate the special needs of children, who could not cope with long waiting times.

This mother was also concerned that GPs tended to focus on the parent, rather than the child with a disability, and would make generalisations about medical conditions, rather than taking an individual patient approach. She felt this meant that children with disabilities received a differential service, where issues such as weight were not treated with the same attention, as it would be with normal children.

The Key Stakeholder from the African charity pointed out that black children with disabilities could be at greater risk from witchcraft.

“In some families the parents might actually believe that there’s something wrong with their child, their child is possessed”

“...they’re being emotionally neglected because the parents think they’re, you know they’re possessed, that they’re evil children.” OKP R

This participant did not feel that GPs had the knowledge of normal parent child interactions to be able to pick up the subtleties, which might help them identify risk factors.

GPs’ participation in training

All the Key Stakeholders felt that multi-agency training was very important, as it provided the opportunity for GPs to develop a shared understanding of the issues for each professional group. Despite this, there was an overall acceptance that GPs did not take part in multi agency training, although it was acknowledged that new GPs did attend as part of their GP registration. The key reason for the lack of participation by GPs was felt to be the time involved and competing training demands on their time. Four participants suggested that there should be more flexibility about the length and timing of the courses, which were usually scheduled for two days.

Both PCT areas had sought to address the low attendance of GPs at multi agency training, by offering training within the surgeries and for health personnel only. This was viewed as better than nothing, but one person stated:

“Unilateral training tends to reinforce your own kind of view of life and multi agency training always brings some surprises about how differently different people see things.” SCKP A

Constraints on GPs

Time

All but one of the participants felt that lack of time was the key constraint on GPs, although two people commented that other professionals also laboured under time constraints. The high number of registered patients and short consultation times were cited as impacting on the GP's ability to pick up on safeguarding issues. It was felt that this restricted the GP's opportunity to explore issues in more depth with the family and to be able to reflect and consult about possible child care concerns. Two people felt that this did not deter the GP from responding to immediate issues, but noted that this could be very time consuming and disruptive to the whole surgery.

Relationship with parents – conflict of interest

All of the Key Stakeholder professionals stated that the doctor/patient relationship and the need to manage and maintain this while addressing safeguarding issues was a concern for GPs. The fear of being wrong and the potential repercussions of being wrong were felt to lead to reluctance by some GPs to get involved. Some participants felt that GPs had a real fear of being sued for malpractice. The GP would usually be the GP for both the parents and child, and could well be the GP to the wider extended family, and three people noted that GPs did not want to alienate their families. The term 'families' referred to the parents, and nine participants felt the GP tended to be adult- rather than child-focused. It was felt GPs were also concerned about an aggressive reaction, when they raised issues with parents and this could be difficult within the surgery.

One participant felt that the GP focus on the parents was to the detriment of the children:

(the reason)“ ...a lot of our children are missed by the medical profession is definitely because they're invisible – I mean they're right there in the GP's surgery ...the GP hasn't taken the time to talk directly to the child then all the signs are missed and the conflict of interest now comes in because it seems that the child is invisible, even though the medical practitioner's meant to be focusing exclusively on that child in my viewpoint but that's not happening. It could be because of language problems, or it could just be because you know,

the GP feels that the mother should be able to explain better. Which is not always the case” OKP R

The mother with a teenage daughter with a disability felt she had no relationship with her GP. She was aware that he received copies of all her assessments and commented that:

“It would be nice if he picked up the phone once in a while to say he had got a report and ask me how things were going.”

She was aware that there would probably not be the resources for the GP to do this and noted this applied to other professionals such as social workers. When she had taken her daughter to the doctor’s, her experience had been that the consultation was focused on her as the mother, and there was no attempt to communicate with her daughter. She felt GPs had no awareness of the extra vulnerability of children with a disability.

Key Stakeholders held differing views on whether and why there was a conflict of interest for GPs. Three suggested that there was no reason for the GP to feel there was a conflict of interest between the needs of the parent and child, as legislation made it quite clear that the needs of the child were paramount. One said that if the GP did experience some conflict of interest, then this could be managed by arranging for the parents to be seen and registered as patients with another GP or practice. Some participants commented that the conflict for GPs was that they had to consider how to address the issue with the parent, knowing that they were likely to be involved with the family in the long term future. Two people felt the GP might have more difficulties, where the level of concern was more subtle, such as where children appear to be suffering from neglect or emotional abuse. One said the GP may well choose to manage these situations without referring to children’s social care services, to avoid jeopardising the relationship with the parents.

Three participants felt that there would be a conflict of interest for GPs, where they felt they could not believe that child abuse was happening in a particular family, whom they had known for many years.

“We’re all human beings first before our professions, so that I think for GPs who I believe know the families... they have a role as the GP to the parent or

carer and to the child and so sometimes 'where does the allegiance lie?' Is it with the child or is it with the adult?' KPSL H

One participant, a very experienced doctor, stated that many GPs would try to seek a medical explanation rather than have to confront the fact that the child had been abused. This person raised the issue of white middle class abuse as a class and cultural issue for GPs.

"It's hard for a GP to think in a nice family with professionals, you know they all want it to be just a one off, they don't want to believe that this really nice family..." SCKP L

Another raised the difficulty for a GP where information that needs to be shared is likely to place the parent in the criminal justice system, and two people gave examples of where GPs had simply told the patient to stop the offending behaviour.

Confidentiality – information sharing and consent

The importance of confidentiality links closely to the GP's relationship with the family and parents in particular. Two participants said they thought it would be difficult for the GP to ask for consent to share information and to know what is appropriate information to share.

One health participant stated that in her experience most families did not mind having information shared and it was unusual for the GP not to get permission.

Two participants stated that GPs often had more relevant information to share than they assumed to be the case. Three people felt the GP's confidence in this area linked to their general awareness and knowledge of child abuse and reflected the training they had undertaken. One participant questioned whether GPs saw any value in sharing information, if they had no confidence in the system.

"If ... I've no confidence in the system... what social workers or anyone else will do with it, is going to be in the child's best interests, then I can see why ... for me would erode the need to share it." SCKP J

The mother of a child with disability expected the GP to keep information confidential and, if it was felt this needed to be shared, that the GP should discuss this with her, and if she refused permission, the GP needed to persuade her that the

information had to be shared. She observed that GPs tended to present to parents what they intended to do and who they would be contacting, rather than asking the parent for permission to do this. This effectively avoided the need to negotiate consent with the parent, unless they challenged the GP's plan of action. She felt that as most parents would want the best for their child, it would be unlikely that a parent would refuse consent, but could see that the possible breach of confidentiality created a dilemma for the GP. However, she was clear that the wishes of the parent had to be secondary to the wellbeing of a child in danger, whilst acknowledging: *"It's not an easy job to decide if a child is in desperate danger."* OKP S

She also considered whether a GP should withhold information from a parent that had arisen during a separate consultation with an older child. She considered that if parents were to fulfil their parenting responsibilities, then they needed to know this information, and likened it to the fact that if the police found a child doing something inappropriate, then they would automatically inform the parent. She also felt there was a dilemma here for parents who wished to be involved and in control, while being aware of the emerging independence of their children.

The GP network and interprofessional working

A few participants said that they thought GPs were unsure of the pathways and procedures they needed to follow, and one suggested that the fact that GPs did not feel part of the child protection network could impede the referral to other agencies. Six felt that GPs did not see themselves as part of the partnership for safeguarding children. These participants viewed GPs as being on the periphery of the multi-agency network, and one noted the potential impact of this distance from other professionals.

"I don't think they're able to address issues with the parents, and actually the more distant you are from the child protection process – the group of people that know each other and work together on a regular basis – probably the more isolated you feel and the more difficult it is to raise contentious issues."

SLKP K

Opinions on multi agency information sharing in both PCT areas were equally divided; half of the participants felt this worked well and had improved recently, but could improve further. The Key Stakeholders tended to think of the multi-agency

network being with children's social care services, health, the police and education. Three people indicated that they did not include GPs in this analysis.

"I don't think there's probably enough kind of alliance, or indeed shared understanding between GPs and child protection professionals." SCKP J

It was noted that information sharing was a two way process and that GPs felt they did not get feedback.

"The GP's more likely to give be able to give information that's relevant to the child protection investigation, if they understand the context of the reason for the child protection enquiry being made, and you know it works both ways, GPs have to ask that social worker 'what's the child protection investigation about?'" SCKPL

Half of the LSCB participants (8/16) thought agencies were not linking as closely together as they could, and this included all agencies as well as GPs. One person stated that collaboration and information sharing within agencies was also a problem. Another backed this up by suggesting that, while GPs find it easier to share information between health professionals, it could not always be assumed that the GP would liaise with the health visitor or school nurse. Four participants commented on the importance of the GP having good links with the health visitor and other health personnel, such as midwives and school nurses. Two expressed concern about recent changes in health visiting, which could limit the contact between the GP and health visitor.

Police personnel in both PCT areas (2) expressed their frustration that they had been unable to establish a dialogue with GPs. They felt GPs, along with children's social care services did not always understand the immediacy of a situation. Particularly in the area of sexual abuse, they felt that GPs did not see the wider picture and consider the situation beyond the victim and perpetrator.

Four participants noted the value of having built up relationships with people from other agencies over the years and the importance of trust. Conversely, three noted the difficulties that arise when there is no relationship. One person summed up this difficulty, linking it to information sharing as follows:

“The issue that addresses it, is that you have got mutual respect and you know what’s going to happen when you share information and you can trust the person you share information with. But how can you, when you don’t know them?” SCKP Q

Three participants in the Shire County commented that the system of referral through a central contact point militated against good information sharing and relationships, with not only GPs, but with other key people, such as health visitors and the police. This was perceived as: *“...bureaucratic and unhelpful.”* SCKP Q

This was especially felt when referrers could not get their calls answered or had to leave a message on an answer machine.

Key Stakeholders in both PCT areas commented on the threshold for referrals to children’s social care services. Four felt the thresholds were too high, and this in turn deterred GPs from making referrals, as they felt they were not acted upon. It was suggested that the referral would have to be a matter of *“life and limb”* to get a response. One person felt the GPs also had too high a threshold for referral (i.e. left too late). In both areas comments were made about referrals for neglect, and it was noted that these were not going to get social work input, unless they were very severe cases. Referrals involved the completion of a lengthy referral form. One person in the South London PCT area stated that the pressures on the Assessment Teams in children’s social care services was such, that the quality of the referral was extremely important in securing a service. This was viewed as a problem for GPs who:

“...don’t want to play anyway and if they do make a referral it’s quite hard to get through the system.” SLKP K

5.4 ANALYSIS OF FOCUS GROUPS

Three focus groups took place to gain the views of patients about the role of the GP in safeguarding children and opinions as to how GPs should manage issues of consent, confidentiality and conflicts of interest. There was a group of young people, a group of young mothers and a group of South Koreans. All three groups were drawn from established groups of people who knew each other well, although two people in the young persons' group were less sure about this.

The focus groups followed a similar format, with the facilitator asking general questions about confidentiality, then seeking more specific views about the participants' own experiences of GPs and how they felt GPs should respond to child protection concerns. They were also asked how they felt the GP should respond in response to several scenarios (see Appendix 4, Document 2).

This section presents the profiles and discussion points for each focus group, then goes on to compare the groups' responses to four scenarios.

The young people's (YP) focus group

Profile of the YP group

This group of 12 young people (five male and seven female) were living in the area around the South London borough. They all used the advocacy service run by a charity and had all been children 'looked after' by the Local Authority. The young people were aged between 17 and 20, and four of them now had young children themselves. Six of the group (three male and three female) were from ethnic minorities, and several of them had formerly been asylum-seeking children from Eastern Europe. Although English was not the first language for some of the participants, all of the young people appeared to have a good comprehension of the English language and it was not necessary to have an interpreter.

YP Group discussion

The young people all thought that GPs should keep confidentiality, but then went on to identify circumstances where this could be breached. They felt if something affected other people such as mental illness, a child was being abused, or a person was putting themselves or others at risk, then they expected the GP to tell someone.

“If it affects other people, then obviously he’s not going to keep it to himself. He’s obviously going to get someone else involved. Or if he feels for example you can’t help yourself or you don’t know how to get yourself out of that situation, then obviously he’s going to get someone else involved.” YP

One of the group felt this would apply if you were suffering from a serious illness, although others felt in this circumstance the GP should respect the wishes of the patient and should not override consent. Eleven of them felt the GP should ask permission before divulging information, but if this was not forthcoming and *“it was something serious”*, the GP should tell someone anyway,

“If you’re putting yourself at risk, or other people at risk”. YP

The group had a sense of the need for the GP to make decisions for the public good.

“It doesn’t matter what you say; if you’re harming people around you, he’s going to have to help other people.” YP

A GP sharing information with health professionals was viewed as more acceptable than sharing it with other agencies, such as children’s social care services. Three of the group indicated that the health visitor and midwife were the health professionals who knew them and their children best.

“I mean your health visitor should know you well enough anyway to say to the doctor ‘No, the child’s fine, ’cos that’s what they do... the health visitor should know whether your child’s all right.” YP

They felt that the health visitor would be the person giving information to the GP, rather than the other way round.

Where children were at risk, nine of the group felt the GP should contact children’s social care services. However two people suggested that the GP should take time over this and *“double check”* with follow up appointments to see how things were going, as they were concerned about the implications of the GP reporting unfounded concerns.

“Could you imagine if he reported her and there weren’t no sign of abuse? Like there’s nothing worse than being wrongly accused.” YP

“Pretty much one of the worst things you can do in life isn’t it, abuse a child, let alone like your own one or whatever.” YP

The group could not see that a GP might feel a conflict of interest between the parent and the child at risk. They were very clear that adults were in a position to look after themselves, whereas children were not so. If there were child protection concerns, all the views expressed that the GP had to report these.

“We’re all old enough and wise enough to look after ourselves. Children can’t defend themselves, so when it comes to children something needs to be done straight away, whether it’s conflict or not.” YP

One of the respondents had been asked questions in a hospital A&E department about how her child came to be injured. She reflected on how she had felt about this.

“Well I had to go to hospital a little while ago ’cos my daughter fell out of the bath and hurt herself, and I got asked questions, and even though it was uncomfortable, I was pleased that they were doing it, because I could have been abusing my child, they don’t know.” YP

It was not clear whether the GP had made the referral or whether the mother had simply taken her child to the hospital following the accident, but her comments highlighted the mixed emotions she experienced.

None of the group participants felt that the GP knew them or their children well. They complained that it was difficult to get appointments: “...they can’t get you out quick enough”, and they were too interested in prescribing. In contrast two members of the group stated that when they were ‘looked after’ children, the GPs had asked them a lot of personal questions and this had been quite annoying.

“They ask too many questions. They like to know really like private questions, confidential questions. They really do like ask loads and loads of questions.” YP

One of them said her GP had broken confidentiality and told her foster mother everything about her.

“I mean my doctor was really pally with my foster carer so it weren’t about, he didn’t ask me any questions, he just went and told her everything, so it was

just like a friendly conversation that happened, didn't involve me apparently!"

YP

The group shared experiences of the GPs at the practice where most of the young people were registered. For eleven of the group, visiting the GP was not a positive experience and they felt the GP did not have time for them.

"I'm trying to talk to her and she kept looking at her watch like this....and she was going 'I do have the next patient in a minute or two...' And I was like 'Yes, cheeky cow, you're supposed to be my doctor!' Do you know what I mean, you're supposed to listen to me!" YP

One person recalled having a good experience with a GP while at university and noted the difference:

"He actually sat you down and like, talked to you for quite a long time..., not like you know, they sit around and don't even look at you, he just writes down while you actually explain what you're doing, and then by the time you've finished he's already written what you've got and he gives it to you and you just go, that's it.

Whereas this guy actually sat down, talked, see what the problem was for example, and he pointed me to go and see somebody... and then the day after he said 'I want to see you first thing in the morning, nine o'clock.' And then you feel like oh, he actually cares a little bit." YP

The group indicated that the GP had a role to play in child abuse and appeared to have expectations around this role:

"If GPs were doing child protection alright it wouldn't be happening." YP

The young mothers' (YM) group

Profile of the YM group

This was a group of seven young mothers who, along with their pre-school children, attended a 'Cook and Chat' group which they ran themselves with the support of two workers from the charity. These women were all white British and under 30 years of age. The women lived close to, but not in, the South London PCT.

YM Group discussion

All members of the group expected GPs to keep confidentiality, but commented

“...if they suspect that something’s wrong with the child then they have to act on it.” YM

In the context of concerns about children, they said this had to be taken on a case-by-case basis and would depend on the circumstances. The group were asked if they felt the GP should respect a mother’s wish for something not to be reported, and one commented:

“...it’s not the woman’s choice ’cos she’s in a threatening situation, but she’s putting her child in a situation, and they haven’t got the choice whether to be there or not, where she has. So I think the doctor should say something.” YM

The group had strong views about who the GP should contact, when there were concerns about a child’s welfare and, without exception, stated that they would not want children’s social care services involved as they felt this was *“a bit extreme”*. They commented on the stigma of this and the fear that their children might be taken away. They thought the health visitor could be the *“first port of call”*, and only if that did not work, should the GP contact children’s social care services.

All of the mothers felt that GPs were unlikely to pick up concerns about children:

“I don’t think you’re in there long enough for them to realize.” YM

There was a great deal of discussion about GPs at one particular practice frequented by nearly all these mothers. The mothers indicated that they did not have a relationship with their GP and tended to see whoever was available. They felt GPs did not have time for them and would only go if they needed some medicine.

“I don’t think our doctor even knows the kids are there! You go in so quick, I just don’t even think they know the kids are there. They just kind of like scan a bit of thin air, ‘Ok have some tablets and go.’” YM

In this practice the mothers felt, while one doctor was quite good with children, others lacked awareness.

“I don’t think they’d notice if there was anything wrong with her. I don’t know, it just seems like you have to tell them and then they just check that one

thing. But I don't feel like they actually take notice of how she's doing like...I don't think they really take that much notice that she's even there." YM

One mother had had a good experience with her GP and reported positively on both her own and her child's relationship with her GP.

"We both saw Dr J the same day and he makes you feel reassured, you're not wasting his time, come back whenever you feel like it... he kept saying 'Come back, phone me, you're not over-reacting' and he made you feel so you know, that you weren't panicking about your kids." YM

One participant who attended another GP practice also gave a favourable report

"...it's absolutely brilliant, they don't rush you out. I was in there with my doctor for over forty minutes the other week. Just crying and talking, he weren't even trying to rush me out the door, which I thought was really good."

YM

All seven group members felt that the health visitors and practice nurses knew them better than their GP. The health visitor was regarded as the significant health professional with regard to safeguarding children. The mothers said that they maintained contact over time and got to know them and their children.

"Doctors will only see you at the beginning but the health visitor and that will see you all the way through." YM

"Most doctors don't know mothers as well as health visitors ...Doctors just see them for illnesses whereas when you go to see the health visitor you talk a bit more." YM

They felt that the GP should discuss with mothers and seek their permission to contact the health visitor, but acknowledged that this did not always happen. Two of the mothers described how helpful the health visitor had been in supporting them.

"I went to my doctor feeling down and he's now got in touch with the health visitor, so the health visitor comes and sees me on a weekly basis, me and my two." YM

The South Korean (SK) Group

Profile of SK group

The group comprised two men and two women, who were all originally from South Korea. They attended the same church and lived in outer London. The group included one married couple, who already had a young child and were expecting another baby shortly. The other two people were involved in church projects for young people. The two women spoke little English, so the men acted as interpreters for them. Any direct quotations or references to comments are made on this basis.

SK Group discussion

Members of the group explained their perceptions of the difference between the medical system in South Korea and in England. In South Korea they feel they have a faster system, but noted that even with health insurance, access to medicine was expensive. This may deter people from going to the doctor. They felt the fact that people had to pay to visit a doctor had implications for children at risk.

“...actually doctors believe the family, the child’s family so much. I mean they may have doubts in their mind but because they are all paid, and it’s all private! So they just go along with their stories.” EKF

The group expressed the view that there is no child protection system in South Korea. However, from further research, the Korean Child Welfare Act 2000, Article 29, prohibits abusive behaviour to children and there are various Acts in the Criminal Law, which can be used to enforce this. The group stated that traditionally close-knit extended families are seen as a protective factor for children, but they noted that cultural changes were impacting on this,

“...we used to have big families and children can be seen by grandparents and other relatives you know, neighbours – we are all close you know, all very close so ... child abuse used to be prevented because of the closeness and because of the community. But nowadays in the Korean society, just they have the one child, and parents don’t have many relatives and close friends. It becomes like Western society so these kind of problems arise often.” EKF

The group stated that in their culture, “*abuse used to be almost zero*” and they felt Koreans would react very badly to allegations of child abuse.

“So I think that is main difference where we contact the GPs. If they see a bruise and they ask for certain, they ask certain questions, Koreans get really angry because of our tradition...parents will be really angry if doctors actually treat them like you know, they are abusing their child.” EKF

All four members of the group expected their GP to maintain confidentiality and said they would trust him to do so. One then added that this would be “*health wise*”, but not if it was something criminal. In these circumstances, they said it did not make sense to seek permission to disclose information. They did not expect a GP to keep child abuse confidential. One of the group queried the overall confidentiality of information held by the general practice, as he had recently had the experience of a salesman telling him that his company had bought personal contact details from the NHS.

The group talked of their experiences with their doctor’s practices and stated they did not have confidence in their GP.

“We are in a minority community. If it’s like, if we go to GP, doctor is, white doctor.” JKF

The couple with the baby felt that the surgery staff had “*not been very kind*” and they had been refused an interpreter, despite a notice advertising this service. They felt that language was the most difficult part of going to the doctors, and noted that if the GP cannot communicate with people, he will not be able to pick up child abuse or conversely establish if something was an accident.

“...because of interpreters and things, it just delays it... It takes twice the time...Doctors - they just want to do things quick, and just want to get rid of the patients, I think.” EKF

This couple stated they had only seen the midwife and health visitor twice in the year since their baby had been born, and had been upset when the health visitor misdiagnosed yellow jaundice, due to her lack of cultural awareness and adjustment for skin colour, and sent them to hospital.

Focus Group responses to scenarios

All three groups were asked to consider scenarios similar to those put to the GPs and derived from the Delphi panel vignettes. The groups of young mothers and young people gave their views on all four of the scenarios on how the GP should respond (Appendix 4, Document 2). The South Korean group were asked to consider only two scenarios, due to time constraints arising from the need for translation to the two members who spoke little English.

Focus Group Scenario One

‘A mother with two young children from an ethnic minority who was expressing suicidal thoughts and saying she did not want any help.’

Young people’s group

The group thought the GP would consider the children’s needs and felt the dilemma for the GP was that the children were at risk and the mother was at risk, and he (the GP) was faced with a mother not giving him permission to take action. They suggested that the GP should take time to talk the mother to persuade her to accept help, but if this did not work, then the GP should seek it anyway.

“I think he should try and talk to her more first ’cos you can’t, if she don’t want the help she’s just not going to go to the appointments, so the GP needs to make her want help.” YP

Young mothers’ group

The group felt that the young mother’s refusal of a referral for help indicated that she was not thinking properly. They thought she would not have visited the surgery if she really did not want any support. They felt the GP should contact the health visitor first, then a psychiatrist, and only if these interventions did not work, should the GP contact children’s social care services. As they discussed the case, they reconsidered the interventions needed.

“If she’s already thought about killing herself that’s quite an extreme case isn’t it?” YM

They suggested the GP should override the mother's consent and consider "*sectioning her*" (under Mental Health legislation). They also identified the risk to the children.

"Cos what would happen to those two pre-school children if she did decide to actually do that? Who's going to be there if she's a single mum?" YM

They concluded that the GP would have to contact "*social services as well. You'd have to get social services involved for the sake of the children. Don't you reckon?*"

YM

South Korean group

The group members were quite clear that the GP should override the mother's consent and get her some help. They felt this was justified to protect the children and to provide help to the mother through a psychiatrist and maybe social workers, who they thought could be involved in taking care of the children, while treatment is in progress.

Focus Group Scenario Two

'A thirteen-year-old who thought she was pregnant by a family member, did not want any one else involved and only wanted help with a termination.'

Young people's group

The group felt the GP had to tell the girl that someone else would need to know and that the information could not remain confidential. They thought the GP could ask the girl to make a further appointment with her mother. The group discussed whether the fact that she said she was having a sexual relationship with an older family member should influence the GP's response. They all agreed that the GP should try to find out more, as the girl could have been forced into the relationship, and they felt it had to be reported to children's social care services and the police. If the person had been a 16 year-old boyfriend, they felt the GP should respond differently and try to persuade the girl to tell someone, as it was important that she was not frightened off. However, they felt even in this scenario, the girl did not have a choice, and the GP would not be able to keep the information confidential.

“He’s going to explain to the girl for example ‘You can’t do this all by yourself because you’re going to have to have somebody adult with you, so whether you like it or not somebody will know about this.’ Just be frank with them straight away.” YP

Young mothers’ group

The group were very clear that the thirteen year old was still a child and the GP should definitely contact children’s social care services and the police, as this was ‘child abuse’. They also felt the GP should reassure the girl, as she would need help to make decisions to “*get out of the situation*”.

South Korean group

Initially one of the women in the group stated that the GP should arrange the termination. However, after more discussion, the group concluded that a termination would be dependent on the duration of the pregnancy. They also thought that the GP should contact the family and the police to prevent it happening again, and should do this even if the young girl did not agree.

“For the prevention of that happening again I think she is saying it is better to contact the family about the situation.” YML – EKS

Focus Group Scenario Three

‘A mother with learning difficulties taking her eight year old daughter to the GP with an ear infection. The daughter was very overweight and also had head lice.’

Young people’s group

The group said the GP should talk to the mother about head lice and about a referral to a dietician. It was suggested that the GP also talked to the child to find out how she was on a day-to-day basis. However, they did not feel the mother should let the GP talk to her daughter alone and one commented

“I wouldn’t let my daughter see the doctor on her own, well you don’t know what sort of doctor it is, you wouldn’t leave any child on their own with someone they don’t know.” YP

Opinions were divided as to whether the GP should override the mother's consent. Some felt that the GP should not refer on or seek other help, if the mother did not want this, while others felt that there would probably be other services involved already if the mother had learning difficulties. However, the consensus was that for this child

"She's just not maybe being looked after properly, but I wouldn't say that's child abuse." YP

Young mothers' group

The group did not see these problems as indicative of the mother not caring for the child properly and offered practical solutions. They suggested that the GP asked the mother to bring the child back to the surgery the following week to see if the head lice had gone, and pointed out that the mother may not be able to afford the lotion, as you cannot get this on prescription. They felt the GP should refer to the health visitor, but would need to discuss this with the mother. Some thought the weight issue could be due to lack of opportunities for exercise and said there was plenty of advice around about healthy eating. They suggested that a referral to a dietician would be appropriate. They did not feel the GP should make a referral to children's social care services and saw the problems as health issues, rather than neglect. They felt if the GP wanted to refer to children's social care services, he should talk to the mother about this as it might *"scare her"* and is such a *"stigma"*. One commented on how the GP could justify doing this without the mother's permission.

"Well it is breaking her trust if she said no. But then he's just looking out for the welfare of the child." YM

Focus Group Scenario Four

'This involved a nineteen-year-old pregnant woman with a history of alcohol and drug abuse, who already had two children, and the doctor notices that she has considerable bruising on her arms and legs. The mother mentions that her little boy is very naughty and her partner regularly gives him a good hiding and that she agrees with this discipline.'

Young people's group

The group felt the GP should spend time with the young mother to discuss her situation and make an assessment. There was some disagreement over the urgency of the situation. One suggested that the mother should be asked to bring the children to the surgery the following week, on the grounds that the child had probably been suffering a long time and it was better to check this out to be 100% sure, so proper action could be taken. Another stated it would take children's social care services at least two weeks to visit anyway. One felt that the mother "deep down" wanted help and, if she would not agree to this as she was too frightened, then the GP should contact the police. Again the group felt that the GP should not just break confidentiality, but should spend time getting the mother to agree to information being shared.

"I don't think he should break confidentiality, I think he should get the person – whatever circumstance – to realise, you know she obviously realises she needs help, in which case she just needs a few words of encouragement to get to the place where she needs to be. I don't think he should break confidentiality at all, 'cos your life's your life." YP

Young mothers' group

The mothers considered the difference between smacking and beating and concluded it should be referred straight to children's social care services.

"... straight away. 'Cos you don't know what he's going to do" YM

They were asked how the GP should respond if the mother asked him not to do this as she feared her partner might hit her. The mothers felt the GP had to make a referral without consent and added that the mother needed help to get rid of the partner.

"...she needs to be in touch with someone that deals with domestic violence or something to, to get him out." YM

5.5 ANALYSIS OF DELPHI FINDINGS

The project sought to use the Delphi technique to gain from a panel of people with specific but varied expertise, knowledge or experience their views and expectations on the role of the GP in safeguarding children. The panel would provide wider perspectives to be considered alongside the views of the GPs, Key Stakeholders and focus groups who participated in the other parts of the study, drawing on a wider national spread than the selected PCT areas, and including people with different roles and interests in safeguarding children. Vignettes were developed for use with the Delphi panel to highlight issues in particularly contentious or problematic cases, and some of these were used in other parts of the study for comparison. It was anticipated that the case material generated from the vignettes and the statements of principles could be used to inform the development of good practice examples and possible training materials.

Introduction to Delphi findings

The Delphi panel drew on key professionals in health and social care, education, research and the voluntary sector including a number of senior GPs (a quarter of the panel initially). For the purpose of this study, expertise included those considered 'expert by experience' (Collins and Evans 2002) as well as those with relevant formal or professional qualifications. 25 participants completed the first round, 18 completed the second round; rounds three and four generated 14 responses each. Responses from the GPs within the Panel were as follows: six responses in round one, four in round two, two in round three and three in round four. Lists of the panel expertise and membership (where permission was given) are contained in Appendices 5 and 19.

The Delphi process involved four iterations of questionnaires which sought to establish a consensus view of the panel's understanding of conflicts of interest in the context of safeguarding children and the principles that should guide a GP when such conflicts arise. To assist this process, the panel was presented with four vignettes and asked to comment on how the GP should respond to these and from whom the GP should seek advice.

Round One Questionnaire generated a wealth of data in common with Powell (2003), while rounds two, three and four sought to generate consensus statements (where

there was over 75% agreement) in relation to the selected areas presented (detailed more extensively in Appendices 7 – 16).

Panel's understanding of conflicts of interest

Thirteen statements derived from the responses reached consensus in relation to the Panel's understanding of 'conflicts of interests in the context of safeguarding children' (Appendix 9, Document 2). From these thirteen, the four reaching highest agreement by the Panel are, in descending order:

- where there is a conflict between the care of a patient and the interests of a child
- where the interests of an individual patient conflict with interests of other patients
- where the needs of a child are at odds with those of the parents or others
- where each individual has an interest but where protecting the interests of one individual might put the other at risk

Statements of Principles that should guide a GP

The Panel were invited to suggest 'principles that should guide a GP when conflicts of interests occur in the safeguarding of children.' From this, 42 principles reached consensus (Appendix 10, Document 2; see also Appendix 17). The following four, in descending order, were rated as the most important:

- the number one principle is the safety of the child
- to do nothing if child abuse is suspected is not an option
- The cardinal principle is that the welfare of the child is paramount
- Where conflicts with the interests of adults arise, the welfare of the child is the over-riding consideration.

The professionalism of the GP and their duty to safeguard children and share information with appropriate agencies was also rated as highly important alongside transparency, honesty and a willingness to admit mistakes.

Questions relating to four Vignettes

The four vignettes explored issues relevant to the safeguarding of children (parental mental health, drug and alcohol use, domestic violence and learning disability), drawing on areas identified as likely to affect child well being (Messages from Research 1995, 2001), and suggested a range of conflicts of interests for a GP, where a parent presents in a consultation with a health issue relating to herself or her child. These are summarized below (see Appendix 6, Document 2 for full details):

Summary of Delphi Panel Vignettes

Vignette 1 featured a mother (Comfort) of two pre-school children with a history of depression and expressing suicidal feelings. Her name suggests a cultural dimension but this was not made explicit.

Vignette 2 featured a teenage mother (Elaine), who is pregnant, and has two young children. She has a history of alcohol and drug abuse and presents with bruising, saying that her partner 'comes from a culture that believes in discipline' and that he regularly gives her son 'a good hiding'.

Vignette 3 featured a mother (Joanne) with learning disabilities who brings her eight-year-old daughter (Freya) to see the GP. Freya has an ear infection, is overweight and appears to have head lice.

Vignette 4 featured a thirteen-year-old girl (Fiona) who fears she is pregnant and discloses that she has been having a sexual relationship with a family member for two years. The GP has been the family doctor for twenty years.

"How should the GP respond?" in relation to each of the vignettes?

The data from Round One relating to this open-ended question was distilled initially into a total of 64 statements across the four vignettes; subsequent rounds added new statements and consensus statements were generated, with a resulting 67 statements agreed overall. 20 statements overall were not agreed (detailed in Appendix 11, Document 2)

In relation to Vignette 1, the 23 final consensus statements (incorporated in Appendix 12, Document 2) recommended a wide range of GP responses such as: assessment of

mother and children, consideration of appropriate mental health interventions, the need to develop a rapport, to use professional judgement and to keep comprehensive documentation, attention to consent and confidentiality, involvement of the health visitor, informal discussion with a social worker, discussion of concerns, making a referral to children's social care services and not making assumptions regarding cultural needs.

For Vignette 2, the 18 consensus statements emphasised: assessment and investigation regarding bruising and chastisement of a child, the development of a rapport, documentation, the discussion of treatment options, provision of information about domestic violence resources, discussion within an inter-agency framework, involvement of the health visitor and midwife, consideration of the consequences of disclosure and referral to children's social care services.

Vignette 3's 15 consensus statements supported: the adoption of a non-judgemental approach, enquiry as to whether the parents would welcome support, the offer of treatment, non-complacency, a consideration of resources, inclusion of the child in discussion, explanation of the need to liaise with a school nurse and teacher, the involvement of an advocate, the learning disabilities team and a dietician.

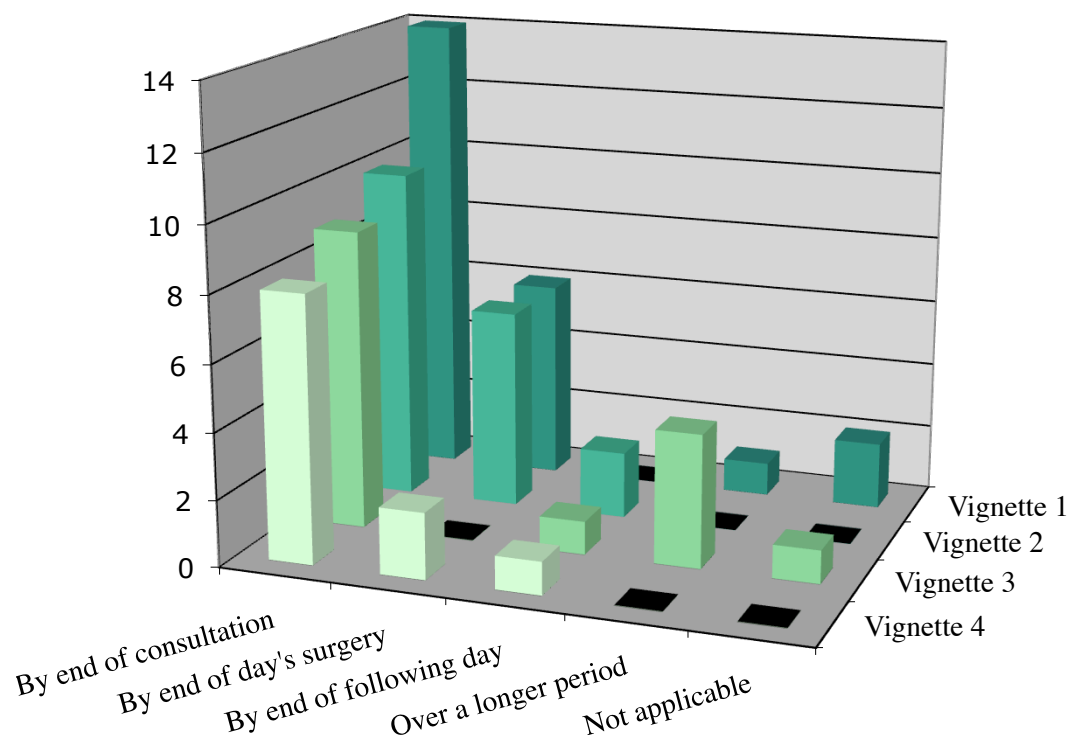
In Vignette 4, the 11 consensus statements agreed: the GP should do a pregnancy test, the approach should be non-judgemental, that he should obtain information, place limits on confidentiality, assess mental capacity, share relevant information, have a female chaperone and make an immediate referral to children's social care services.

Prioritizing the agreed "How should the GP respond?" statements

With the exception of Vignette Three, most of the suggested GP responses were viewed as of high priority, and responses from Panel members showed a correlation between their view of seriousness and the urgency of a response required. The panel expected GPs to action most response statements by the end of the consultation (Appendices 13, 16. Document 2). Vignette 1 involving a mental health issue was regarded as needing the most urgent attention within the consultation.

Table 19 below shows a graphical representation of the different timescales for the actions agreed within each vignette proposed by the Delphi Panel members.

Table 19: Delphi Panel: Expected allocation of Actions/Statements to Time Periods by GPs



Factors identified as influencing the GP's response times were the GP's assessment of the situation, their prior knowledge of the family and child, the difficulty of making immediate contact with other professionals and the need for multi agency involvement.

Sources of Professional Advice

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?' the panel identified 39 resources (Appendix 15, Document 2).

The top ten sources /resources listed are:

1. Named/designated professionals for safeguarding children
2. Experienced colleagues in the practice
3. Children's social care services

4. General Medical Council
5. Local paediatric experts/team
6. The advice of Senior Partner
7. GP procedures manual
8. RCGP's statements of principles
9. Health visitor
10. Legal frameworks e.g. Children's Act

Themes Identified by the Delphi Panel

The Delphi panel highlighted the same key areas of potential tensions and conflicts of interest for GPs in safeguarding children as the other groups in this study. These areas centred on the significance of the GP role, the doctor/patient relationship and family focus, responses to child protection concerns by GPs and other agencies, information sharing and the impact of the GP workload and time constraints.

Findings from across all the data sources (literature and policy review, demographic and child protection data in the PCTs, GP questionnaires and interviews, Key Stakeholder interviews, young people's and parents' focus groups and the Delphi technique) are discussed in the next section (6) where these are integrated across emerging themes.

SECTION 6:

DISCUSSION OF FINDINGS ACROSS THE STUDY METHODS

6.1 INTRODUCTION TO DISCUSSION

From the early stages of the research it became clear few of the subjects in any of the studies considered “conflicts of interest” as an issue in isolation from the other tensions that determine whether a GP is actively engaged with child protection. This section places the study’s original concern - to study the ‘potential conflict, between the needs and care of a child and an “alleged perpetrator” when they are both patients of the same GP’ - within this wider network of tensions in the child protection process.

This section is structured to reflect this change in emphasis, starting with

- Consideration of definitions and understandings of interests and conflicts, and the frequency of child abuse and neglect cases and dilemmas experienced by GPs (6.2).

A review of the role of the GP in safeguarding children is then considered within seven key areas of tension and/or conflict that have emerged:

- The Doctor/Patient Relationship (6.3)
- The Role and Expectations of the GP in Safeguarding Children (6.4)
- Decision Making in the Safeguarding Process and Partnership (6.5)
- GP Relationship with Other Children’s Services (6.6)
- Information Sharing, Confidentiality, and Consent (6.7)
- The Business Framework for a GP Practice (6.8)
- Forgotten or Invisible Children? (6.9)

The two final sub-sections provide:

- Best practice examples emerging in relation to managing tensions and conflicts of interest (6.10), and
- A Summary of the Strengths and Limitations of the study (6.11).

Key findings are presented at the end of each subsection and a summary of the set of key findings is presented in full in Section 7.

In considering the discussion of the findings across the methods in the study the following reservations are noted:

- This was an exploratory study, where the response rates from GPs in the questionnaires and interviews were lower than anticipated.
- The GPs in this study, given the sample, are possibly more likely to be biased towards a commitment to child protection and this may need to be taken into account.
- The participants were asked to present their experiences of the incidence and frequency of child abuse and neglect cases in their individual practice but it was not possible to corroborate these independently.
- Whilst half of the study participants were drawn from the two selected PCTs in the South of England, 34 of the GPs completing questionnaires, most of those interviewed, three of the Key Stakeholders, all the focus groups and most of the Delphi panel were selected without any geographical constraint across England. Individual comments cannot therefore be assumed to refer to a common professional and/or geographic context.

6.2 INTERESTS, CONFLICTS, AND FREQUENCY OF CASES AND DILEMMAS FOR GPs

The word 'interest' covers a range of concepts, such as needs, wants, and rights, in various combinations. Findings from the all parts of the study suggest that there are many ways that conflicts of interest may arise for an individual (GP, child, parent or carer). Examples suggested by the Delphi participants included the following:

- for GPs: meeting national targets, conducting GP activities, alongside safeguarding work, whilst protecting their personal life;
- for a child: wanting abuse to stop, while also wanting a parent to remain at home;
- for a non-abusing parent: wishing abuse to stop, but dependent on the income from the abusing parent to sustain the family.

A GP has potentially to respond to and balance a range of interests within and amongst individuals, taking into account legal and guidance frameworks, values for General Practice, and responsibility for confidentiality and caring for the whole family.

Frequency of cases of child abuse and neglect

The data from the sample PCTs indicated in Section 4 that there were 60 children on the Child Protection Register in the Shire County (SC) and 170 GPs, and in the South London (SL) area the number was 241 children, with 225 GPs. The GP numbers represent proportionately total populations but are not linked to the proportions of children, which constitute 19% of the SC population and 22% of the SL area. On an average headcount, only 1 in 3 GPs in the SC might have a child on the Child Protection Register, while it could be that nearly every GP in the SL area would have this experience.

The literature suggests GPs report seeing around 1-2 child protection cases per year (Lupton et al. 2000), and their engagement with these is mostly confined to the identification and reporting stage (RCGP 2005). One of the Key Stakeholders, an experienced paediatrician, challenged the notion that GPs rarely come across child protection, stating that a GP will be seeing risk indicators of possible child abuse/neglect in every surgery, with the presentation of parents with mental health, drug and alcohol, and domestic violence problems, identified as potentially vulnerable parents in the literature (Stanley et al 2003, Cleaver & Nicholson 2007, Cleaver et al. 2007). Different levels of awareness, areas of tension and complexity emerged during the course of the study from the different participant views.

GPs in this study did not report coming across many child protection cases but were able to recall clearly their intervention in the few that they had seen. Reporting low numbers of cases may mean that the occurrence is low, or could indicate lack of awareness or sensitivity, fear of wrong identification or its consequences, or avoidance. Given the nature and size of this GP sample, conclusions cannot be directly drawn but it would seem that incidence is variable and avoidance is an unlikely explanation.

An additional comment, from a GP, suggested that while meningitis might be even less common than possible cases of child neglect, it would be clearly unprofessional for a GP not to be fully aware of the likely symptoms and presentation of this.

Frequency of conflicts that arise

There was strong evidence from the GP questionnaires and interviews, that where issues are clear cut, the framework for safeguarding is well understood and can provide appropriate support and professional guidance to act when necessary. GPs did however recognize the existence of conflicts of interest, even if they reported small numbers of problem cases. Only a tenth of the GPs who returned questionnaires specifically identified a conflict of interests between meeting needs and wishes of the parent and the needs of the child where both are patients. Three of the fourteen GPs interviewed saw attendance at case conference as creating a conflict of interest, where their role as an ‘advocate’ for the parent could be in conflict with possible decisions to remove the child from the family. Attendance, and even the provision of a report were potential areas of conflict for GPs where the needs of the parents and the child were not necessarily coterminous; this could possibly influence their decision whether to participate (Murphy 2004).

GPs also recounted examples of other conflicts and dilemmas, often expressed in relation to confidentiality and information sharing, to responding to s47 enquiries (Children Act 1989) and making referrals, as well as to participation in safeguarding activities. When asked whether they had experienced a dilemma in the last twelve months in terms of confidentiality and information sharing (Section 5.1), over half (55/96) had not, and the others ranged from one to ten instances.

The Delphi Panel (representing a wide range of expertise) identified a number of conflicts of interest as existing and important. The findings from those GPs interviewed suggest that more experienced GPs were both more aware of potential conflicts of interest between the needs of the child and their parents/carers, and more able to resolve them. Key Stakeholders suggested that there should be few genuine conflicts of interest. If GPs followed procedures and are not diverted by individual professional constraints/considerations, then Key Stakeholders appear to think that they should experience few dilemmas. GPs who responded in this study may report few dilemmas because they are a particularly decisive (and experienced) group.

KEY FINDINGS:

Conflicts and dilemmas for GPs in safeguarding children extend beyond the potential conflicts of interest arising from those immediately involved (the GP, child, parent or carer) to include other competing tensions.

GPs in the study provided strong evidence that where issues are clear cut, the framework for safeguarding children is well understood and can provide appropriate guidance to act when necessary.

6.3 THE DOCTOR/PATIENT RELATIONSHIP

Adult, Child or Family Focus? Who is the patient?

Maintaining a positive continuing relationship with parents was identified by almost all the GPs in the questionnaires (and interviews) as an important means to supporting children and families through supporting parents (Murphy 2004). Managing the priority to protect and consider children with managing doctor/family relationships, when the *doctor/parent* relationship was the usual focus of consultation, was the GPs' most frequently cited conflict of interest. This occurred often in health care decisions for children and was made more difficult in circumstances of family breakdown.

Tensions can be created between supporting the family as a unit and treating the child as an individual. Interests may diverge which require balancing multi-professional engagement and professional judgment. Key Stakeholders saw the conflict for the GP arising from the difficulty in separating out the interests of the child from the parent/family and adopting a child as opposed to adult focus. However, where serious harm or the likelihood of serious harm to the child is evident, then all participants agreed that the child's interests must come first.

Whilst the responses from many of the Focus Group members also supported the view that GPs should put a child's needs first, and take action to protect a child if they suspected child abuse, their concerns were pragmatic. They were less concerned with definitions of conflicts of interest, than with the consequences for an innocent parent if the GP got it wrong (discussed in more detail below) - an aspect of the GP's 'Case holder' role as 'sweeper upper' discussed in the next Section (6.4).

Gaining and maintaining relationships

This and the following subsection relate to the GP in the early stages of the ‘Case holder’ role (ibid).

Almost all GPs (90/96) placed great importance on maintaining their relationship with their patients and some (a third) expressed difficulty in addressing concerns about children’s welfare with parents and seeking consent to pass on confidential information. Examples given by individual GPs who were interviewed indicate that, where GPs identified and addressed child protection concerns, in many cases they were able to do this in a way which enabled them to maintain or repair the relationship with the family over time, suggesting skill and sensitivity.

GPs described ways in which the relationship could be used to the advantage of children. One GP, who shared a common ethnic background with several families, described herself as an educator, building on her understanding of their culture and of British society to help parents make adjustments in the family to promote children’s well being.

GPs rated their knowledge of families beyond individual medical information as limited, but the relationship with the patient as important. The discussion in the Focus Groups did not suggest that participants felt they had a meaningful doctor/patient relationship with their GP, experiencing the GP consultation as a service not as a relationship. The majority of these participants stated that GPs did not have time for them and did not even pay attention to their children if they had them. They doubted also whether the GPs knew them that well (comparing them unfavourably with health visitors) and described appointments as routine (necessary for receiving medicine), generally rushed, not necessarily with the same GP, and less than positive, except with certain exemplary GPs. Poor communication with the GP was cited in all three Focus Groups. Participants stated that the GPs tended to focus on the parent. While they wanted the GP to pay attention to their child, they felt uneasy about the suggestion of the GP talking to their child when they were not present. This raises issues of trust, but also highlights that where the concerns are personal, parents/patients may have difficulty themselves separating out their own needs from those of their child. The differing perspective of the doctor/patient relationship by

doctors and some patients needs further exploration and suggests that the GPs' anxiety about maintaining a quality relationship with their patients may not always be based on a shared perception of the quality, and the interpretation of the doctor/patient relationship may also differ significantly between the two groups.

Fear of “getting it wrong”

It is clear that confident, skilled and experienced GPs are making difficult decisions daily, as evidenced in the interviews, carrying through the delicate balance of maintaining relationships, making rapid assessments and setting out a series of decisions including referral on or follow up. From the interviews, some GPs' fears of jeopardizing their relationship with the parent often proved to be unfounded or of a temporary duration. Nevertheless, even one of the more experienced GPs in child protection feared “getting it wrong”, and many identified the fear of harm by intervention. Potential benefit to a child was rarely commented on.

While most participants in the Focus Groups appeared generally confident about the GP's ability to make correct judgements, there was a feeling that the GP needed to take time to make decisions to ensure they were correct. The stigma of being accused wrongly of ill treating a child and being referred to children's social care services was raised as a key concern by all three Focus Groups.

Key Stakeholders and findings from the Delphi acknowledged the importance of the doctor/patient relationship and understood the requirement on GPs to adhere to GMC guidance on the duties of a doctor (GMC 2006). However, some of the participants felt that GPs hid at times behind these principles, due to the fear of the consequences of raising concerns and possibly making a wrong assessment of the situation. Concern was also expressed in the Delphi study that, where GPs had a longstanding relationship with a family, they may become over-confident in ‘knowing’ the parent or carer, which might lead to misjudgement, over-identification with parents, finding it difficult to accept that abuse could occur, just not seeing concerns or becoming inured to an unacceptable level of care. GPs may feel they are operating in safeguarding situations at the boundaries of their professional knowledge and confidence.

KEY FINDING:

GPs see supporting parents as the best way to support children and families; all study participants agreed that where serious harm or the likelihood of harm was evident, the child's interests must come first, but keeping the focus on the child was more difficult.

6.4 THE ROLE AND EXPECTATIONS OF THE GP IN SAFEGUARDING CHILDREN

Significance of the GP in Safeguarding

Overall, the findings suggest that, while GPs, other professionals and the government think that GPs have a significant contribution in safeguarding children, there is a difference of understanding as to what this means in practice and there are still some GPs in the study who doubt their significance at all. The guidance, and other professionals, expect GPs to be involved in all aspects of safeguarding while GPs primarily see themselves engaged in the early identification stages and in the continuity role with families. This study highlighted that the reality of their contribution is mixed. While other professionals are making assumptions about the significance of the GP contribution and their engagement, they also appear to accept their lack of engagement within the process, and their place on the periphery of multi-agency partnerships, particularly in relation to attendance at case conferences.

This appears to be an inherent contradiction that confuses the overall perception of significance for the GP role in safeguarding *every* child, recognizing there will always be variation depending on individual cases and individual GPs.

How does current⁶ policy and guidance contribute to understanding of roles and expectations?

While current policy and guidance identifies professional responsibilities and actions required of GPs, the responsibilities of GPs, as described, tends to be subsumed

⁶ "Current policy" needs to take account of the changing policy context during this study. See Section 1 for commentary on the policy context.

within those of other health professionals, other doctors, or with the GP practice/Primary health care team. Specific references to GPs (e.g. in *Working Together to Safeguard Children*) are limited. As outlined in Section 1.3, these include the identification of children in need and those at risk, and involvement in subsequent intervention.

Guidance from medical professional bodies recognizes potential “conflict” areas, in relation to prioritization of interests (the child’s, public interest), ethical dilemmas (e.g. in relation to GP beliefs about contraception), information sharing with/without consent, and gaining consent from parents/children where abuse where may be suspected (GMC, BMA, RCGP, RCPCH).

There is a wealth of protocol material for confidentiality, information disclosure and sharing and ethical guidance (DH 2003, DH et al. 1999, HMG 2006b, HMG 2006c) as well as locally agreed LSCB Safeguarding Procedures; professional guidance is continuing to develop, e.g. (RCGP 2005, GMC 2007), with some significant developments since this study was initiated. The GMC guidance, in particular, appears to clarify and strengthen the rights of the child in the child protection process and endorses expectations on doctors to share in safeguarding roles, especially in relation to information sharing.

Some Key Stakeholders queried whether GPs had read all the relevant guidance, and some of the GPs in the questionnaires indicated they took a ‘need to know’ approach to guidance and information, so would only read this when confronted with a problem. Levels of knowledge of legal responsibilities and guidance varied across the participants in the project, but were strongly represented in the Delphi panel.

Roles of GPs – many roles or one in safeguarding?

Comments from GPs, Key Stakeholders, Focus Groups, and the Delphi panel members indicated that the role of the GP in safeguarding children is composed of a number of distinct elements extending roles in ‘normal’ GP practice. In the analysis integrating the separate parts of this study and the different views expressed, these elements appear to reflect four different roles that are characterized here as the ‘Case holder’, ‘Sentinel’, the ‘Gatekeeper (or Gateway)’, and the ‘Multi-agency Team Player’.(Table20,below).

Table 20 The Different Roles of GPs in Safeguarding Children

1. The Case holder: In fulfilling this role a GP (and/or Practice) ensures that they are able to continue to maintain, as far as possible, an ongoing relationship with all the members of the family for health and relevant welfare concerns; if there are safeguarding concerns, the relationship continues before, during and after a referral to initiate safeguarding procedures.
2. The Sentinel: this role denotes the recognition and identification of any child/ren who have been abused, neglected, or are at significant risk of harm, and ensures that they are referred or reported according to locally agreed LSCB procedures.
3. The Gatekeeper (or Gateway role) ensures that a health report on an individual case is made available to other agencies (written or verbal) in order for a full assessment to be made or access gained (or controlled) to consultation, specialist knowledge, resources, or intervention/treatment through systems of referral (Gateway). The value of such reports to the safeguarding process may depend on the extent to which these go beyond 'medical facts', can be understood by other professionals, and/or provide new or significant information (i.e. previously unknown to others).
4. The Multi-agency Team Player: this role contributes to wider safeguarding support activities that require continuing involvement with individual cases and a willingness to engage *outside* the practice with other professionals in other agencies.

Separating these different roles may avoid an over-simplistic assessment of the GP's role and a clearer analysis of the unique contribution that could be made by individual GPs themselves, GP practices, and/or other associated professionals. Although these will overlap at times, and the same conflicts and tensions affect each one, the consequences for safeguarding children vary significantly if a particular role is not fulfilled.

The Case holder

The 'Case Holder' role is already integral to the universal ongoing service aspect of GP work in relation to the Doctor/Patient relationship discussed in Section 6.3. It is also significant in affecting all other decisions and actions taken, particularly in relation to keeping sight of all parts of the "jigsaw". This aspect builds on a system of self referral and voluntary disclosure of problems and development of trust over time, and depends on an understanding of a child's health and developmental progress within their family, and knowledge regarding a parent's troubles or difficulties. It may, since the new contract (BMA 2004), be shared with the GP practice, rather than always invested in one GP per family. Careful shared recording systems are vital in this case. One aspect of being a 'Case Holder' is as a 'sweeper upper' when ongoing work with families is affected by developing concerns and any potential 'collateral damage' from child care proceedings if initiated. This may create conflict with the 'Sentinel' role discussed more fully below. Few other professionals would appear to recognize this aspect of a GP's practice.

The significance of this role is clearly recognized by the majority of GPs interviewed in the study (9/14) who saw the continuity role ('Case Manager') and that of 'Gatekeeper'/'Gateway' to resources as their key responsibility, drawing parallels with everyday practice in healthcare, picking up concerns and referring on to a specialist resource/service, as they would with any clinical problem that was beyond their scope to diagnose or treat.

The Sentinel

The 'Sentinel'⁷ role specifically relates to the 'unique' contribution (Bannon and Carter 2002) that each GP, (and member of a GP Practice), can make in:

⁷ This term is taken from its prior use in 'sentinel approach' to research as outlined in US studies in estimating underlying levels of child abuse by Sedlak and Broadhurst (1996) and elder abuse in more recent literature (Geroff & Olshaker 2006). In this research model, sentinels provide observations of an actual or potential abuse in order to establish the underlying level. Statistical analysis is then used to eliminate duplicate reporting.

the identification of children who may have been abused and of those who are at risk of abuse (2.74, Working Together to Safeguard Children)

This role should be shared by all staff in the GP practice (HMG 2006c). In order to be able to fulfil this unique capacity, the GP may be particularly well placed to draw on the opportunities provided as a ‘case manager’, (i.e self referral, long term relationship with the child and parent, and family knowledge), but it also depends on alertness to potential abuse or neglect, and confidence in decision-making and referral, if a child protection concern is identified. Specific training and knowledge may be necessary to ensure:

The GP, practice-employed staff and the (primary health care team) are (also) well placed to recognise when a parent or other adult has problems that may affect their capacity as a parent or carer, or that may mean they pose a risk of harm to a child (2.76)

Key Stakeholders in this study felt that GPs’ lack of awareness of child abuse might mean that they would not identify issues of concern and, in consequence, might not see the dilemmas that could arise or identify a child at risk (where health visitors might see more because of knowing families well). The ‘Sentinel’ role is clearly recognized in the RCGP strategy (2007) and the views of Bannon and Carter (2002) and Bastable (2005).

The self-referral aspect of patient contact provides GPs with opportunities, not necessarily available to other professionals, for early identification of new individuals at risk and a timely or urgent response, as noted by the Key Stakeholders (Section 5.3) and the Delphi panel (Section 5.5). This may be particularly relevant when identifying vulnerable parents as well as vulnerable children. Where parental issues (mental health, domestic violence, drug and alcohol abuse, and, possibly, learning disability) are present, these may be key indicators of concern for children. The responses provided by GPs in the questionnaires in Tables 8 and 9 (Section 5.1), mirrored by the responses to the scenarios presented in the GP interviews (Section 5.2), show notable patterns of response in relation to identification of these indicators of potential vulnerability factors for both children and parents.

However, the GP system of self-referral does not usually follow up missed appointments, raising the possibility that children, especially those suffering from neglect, may fall through the net, if support pathways are unclear and thresholds for intervention not universally shared. This could mean that some children at risk may not be identified early enough, though conversely, if the GP is seen to lose independence by close working with external agencies, this may constrain patient self-referral.

The critical aspect of this role for safeguarding children is to ensure that such cases are either reported or referred to someone who is competent to assess the case and act, and awareness is vital to this. At certain stages of a child's development, the GP might be the most likely professional to identify a new case. All but three Key Stakeholders rated the GP's understanding of families' situations important, and all (19) rated their significance highly especially in neglect cases, where neglect was a process not a single event. Stevenson (2007) reinforces this, when she argues that the GP and primary health care team are best placed to play a preventative and protective role, particularly in cases of neglect, and where children are not yet attending school. GPs themselves thought schools were more likely to be more informed about school age children than the GP practice.

In order to fulfill this role (and before moving on to the 'Gatekeeper'/'Gateway' role), many GPs stated that reflection time and the opportunity to talk situations over with an empathic colleague would be more helpful with complex issues, in relation to either hypothetical or specific concerns, before formulating whether a further assessment or referral is needed.

If the 'Sentinel' role is not fulfilled, then children who are at risk of harm, or who have already been harmed, remain at risk, unless/until staff in another organization/agency identify them.

The Gatekeeper and/or Gateway

The GP acts as a 'Gatekeeper' to the health information that may be requested or provided regarding any particular case (parent, child or family).

This includes appropriate information sharing (subject to normal confidentiality requirements) with children's social care when enquiries are

being made about a child, contributing to assessments, and involvement in a child protection plan to protect a child from harm. GPs, practice staff and other PHCT⁸ practitioners should make available to child protection conferences relevant information about a child and family, whether or not they – or a member of the PHCT – are able to attend (2.77)

The GP Practice, or the individual's GP, is uniquely able to provide an informed report, that integrates and interprets the 'jigsaw' of knowledge as 'Case holder' that a practice holds on individuals and/or families for a multi-professional audience. This might be particularly requested in relation to a s47 assessment of a child at risk or s17 assessment of a child in need (Children Act 1989). This role is expanded in Section 6.7 on information sharing, confidentiality and consent.

The GP acts as a 'Gateway' when they offer/seek access to additional services or support. Access to additional healthcare services is integral to everyday practice for a GP. In these cases the GP would normally discuss concerns with the patient, with a view to making a referral onwards⁹. Where there are early concerns for a child, issues of confidentiality without consent from a parent, may become harder to resolve if the benefit to the child is less clear or likely to be longer term.

If the 'Gateway' role is not fulfilled, then children and parents who need support and help which may only be available from a range of professionals (as e.g. as provided by the Common Assessment Framework introduced between 2006 and 2008 - HMG 2006a, 2007) may not receive this, and children may fail to thrive, be harmed, or remain at risk, unless referred by another professional. Moving beyond the 'Sentinel' and 'Gateway' role, to becoming more actively engaged in child protection, was not generally seen as realistic by the GPs in this study within a service that relies on self-referral.

⁸ Primary Health Care Team

⁹ When the Common Assessment Framework (HMG 2008) is fully implemented, this may provide an improved opportunity for accessing a shared assessment process.

The Multi-agency Team Player

GPs are independent contractors, but are closely linked with GP partners (if in a partnership), are part of the Primary Health Care Team, and see themselves also as part of the medical profession (with close links with paediatricians). In the context of safeguarding children, ‘team player’ here refers to activity within the multi-agency partnership, including decision making and attendance at case conferences, or acting as a primary agent in carrying out a plan “... *in subsequent intervention and protection*” (2.74). The role of ‘Multi-agency Team Player’ is fulfilled whenever the GP practice contributes actively, rather than indirectly (as ‘Sentinel’ or ‘Gatekeeper’/‘Gateway’) to the child protection process. This is expanded in Section 6.5 on decision making in the safeguarding process and partnership and 6.6 on the GP relationship with other children’s services, particularly in the section relating to attendance at case conferences.

Expectations of GPs from others’ perspectives

Having acknowledged that there are differences in views of the significance of the GP role, and considered the analysis of the role in more detail, the expectations of others need review. While views on significance and expectations are closely related, comments from study participants on expectations of GPs are frequently linked to comments on the actualization of involvement as experienced by participants. The Key Stakeholders and Delphi panel members expected that the GP would play a significant and ongoing role in all aspects of safeguarding children, or take on a more central role, but this did not appear to be wholly compatible with the willingness and ability of GPs to meet these expectations in all the types of roles identified above. The mismatch between expectations and fulfillment of all these roles appears to be greatest in the ‘Multi agency Team Player’ activities, and linked to unrealistic expectations of other professionals, difficulty integrating some roles into a GP’s pattern of work and limited communication between professionals.

All the Focus Groups appeared to have high expectations of the GP and expressed disappointment when these were not always met, most notably in terms of relationships rather than roles (referred to in Section 6.3 on the Doctor/Patient relationship). They were even unsure of some GPs’ ability to identify that a child was at risk (in the ‘Sentinel’ role). In contrast, with these unmet expectations, the Focus

Groups rated health visitors very highly in terms of their expertise, accessibility, knowledge of families and the support they could give to parents and children. They appeared more significant to these parents and children than the GP.

The government initiatives and policies were intended to clarify the roles and responsibilities of professionals who may come into contact with children at all stages, i.e. those in need of early intervention, potentially at risk, or actually experiencing harm. The GPs' view of their role primarily as 'continuity' provider ('Case Manager'), 'identifier' of concerns ('Sentinel') and 'referrer on' ('Gatekeeper'/'Gateway') might suggest that, alongside clearer separation of GP roles, the safeguarding roles taken by other professionals, such as the health visitor and school nurse, might need to be more clearly defined. This might bring closer the expectations and the actuality of GP involvement in safeguarding.

KEY FINDING:

Expectations of GPs as set out in Government policy documents were not fully shared by GPs themselves and other stakeholders. GPs interviewed saw their role in most cases as providing continuity and referring patients/families on where concerns were raised, while key stakeholders expected fuller engagement in all stages of child protection processes.

6.5 DECISION MAKING IN THE SAFEGUARDING PROCESS AND PARTNERSHIP

GPs are involved in decisions at different stages of involvement on the continuum of promotion of well being for all children, from prevention through to protection (See Appendix 19, Document 2). This ranges from whether there is a cause for concern, whether to refer on (inside and/or outside health care contexts), and then whether to be involved in further action/intervention. The different GP roles described in Section 6.4 may be relevant in each of these stages.

Sources of information

GPs may inform themselves in a number of different ways, particularly in relation to the initial stage. The Delphi identified examples, such as discussing hypothetical cases, referring to written guidance (including procedures based on law and policy, professional body guidance, and Medical Defence Union advice) and discussion of actual cases with a trusted colleague.

In relation to written guidance, it is not absence that is problematic – at times it appears to be overwhelming and coming from different sources, sometimes profession specific and sometimes aimed at all professionals. In difficult cases, separating the child's needs from the needs of the parents and other family members is highly complex and requires specialist knowledge and skill alongside professional guidance to support the development of professional knowledge. Sometimes this also requires persistence over time.

Professional confidence in making decisions can be enhanced further by advice, consultation, and training.

Sources of advice for decision making and the child protection process

The data collected sought to identify advice sources where there were “concerns”. The GPs in the questionnaires were asked to make suggestions, drawing on practice experiences, as to where GPs should seek advice, while the Delphi panel were asked to relate their answers to hypothetical cases. Sources suggested were highly context related, given that structures for safeguarding children were in transition at the time of the study, and there were different arrangements in the two PCTs.

Two thirds of GPs (67) rated the health visitor as highly significant where there was concern for a child (see also Section 6.6 on relations with health visitors). Almost half (46) of the GPs would seek the advice of health colleagues and/or a paediatrician. Neither route appeared to raise issues about confidentiality and avoided the need for the explicit consent of the parent.

Seven GPs identified as significant contacts the “named and designated nurse” and 16 GPs the “named and designated doctor” for safeguarding children. Some of the GPs interviewed were not clear as to who these people were and what role they played, and it was noted that many of these posts nationally were unfilled at this time. The

Delphi panel members considered ‘named’ professionals to be the most important key sources of advice, before experienced colleagues in practice and children’s social care services, while they ranked the health visitor as being ninth in importance as a source from whom the GP should seek advice.

Where to refer for expert/specialist consultation

Both GPs across the study and Key Stakeholders saw the nature of each case as being particularly relevant. Where there is strong evidence for investigation as a child protection issue, such as a fracture that appears to be non-accidental, professional guidance is clear on the course of action. It is in the less clear-cut cases, where uncertainty is increased, such as in cases of neglect (where it is a process not an event), or in sexual abuse (where disbelief could affect perception) that dilemmas and conflicts of interest can arise. It is increasingly acknowledged and explored in the literature that where there is uncertainty, it has an impact on effective safeguarding mechanisms (Polnay 2001, Lupton et al 2001, Bannon & Carter 2002). Ensuring the child’s interests are considered separately from the interests of the parent/carer may therefore require specialist knowledge.

Forty-six GPs indicated they would refer a child to a paediatrician for an ‘expert’ opinion, which could confirm a diagnosis and give advice regarding further treatment or referral to children’s social care services. This could be either the community paediatrician, (who was often the designated doctor for safeguarding children), or a hospital consultant paediatrician.

In the questionnaires, 84 out of 96 GPs rated children’s social care services highest as the professionals they would consult on child protection concerns. This reflected that they were clear about the legal requirement and their responsibilities. However, the data also revealed that for just over half of the GPs (50), children’s services was not their first port of call, demonstrating that GPs may access a range of people and ways to resolve conflicts.

Thresholds and areas of concern for referral

In the GP Questionnaires (Section 5.1) decisions to refer on to other professionals, when related to parental difficulties and child presentation (Tables 8 and 9), showed non-random patterns in their responses to different categories and variation between

categories. For example, where parents were experiencing ‘domestic violence’, this would be a clear trigger for referral to children’s social care services, with ‘alcohol and drug abuse’ the next most significant factor. A quarter of GPs would refer a parent with ‘learning disability’ to another health colleague, but GP concerns were least with respect to parents in relation to ‘cultural factors’ (defined on p 51), and ‘physical disability’. Many parental factors would be addressed by the GP in a consultation, especially mental health difficulties. In relation to child presentation, GPs identified that where ‘injury’ and ‘neglect’ were evident, these were highly likely to be referred to children’s social care services. Health workers would be involved in all cases where the child or parent appeared in difficulties, especially ‘failure to thrive’ or ‘anxious’ or ‘withdrawn’ behaviour.

The Delphi panel, when asked to comment on a simulated case where neglect was a feature, regarded this as the least conclusive case for child protection referral and intervention; however, the parent in this vignette was also described as having a learning disability. This factor may have raised issues for the panel concerning the rights of parents with a disability, that the parents should not automatically be regarded as ‘poor parents’.

The literature suggested that neglect was an area often given low priority by child protection professionals (Taylor and Daniel 2005, Farmer 2007, Brandon et al. 2008). While the GPs in this study could be considered to be a more than averagely engaged and aware sample, it is notable that ‘cultural factors’ were not highly significant in their consideration, but their awareness of neglect as a potential cause of abuse and their theoretical links with children’s social care services were relatively clear.

Referrals clearly depend on knowledge and awareness of potential indicators of neglect and abuse and the threshold for intervention. As many as 13 of the GPs who completed questionnaires reported uncertainty with deciding thresholds of concern or thresholds for involvement of others, although whether this relates to the nature of the case or different interpretation of thresholds could not be explored in this study.

It was clear from several of the Key Stakeholder interviews that the thresholds for response set by some children’s social care services were set too high and that referrals for neglect, for example, were unlikely to get a response unless they were a

matter of ‘life and limb’. Where GPs believed that there would be little response, or that a response was unpredictable, seemed inappropriate (child protection procedures invoked with “*all guns blazing*” or ‘no action’), or not always in their view in the child’s best interests, at least three GPs spoke of delaying referral for concerns while trying to work on local solutions with the family within the primary health care arena, thus possibly contributing to the view of some stakeholders that it was the GPs’ thresholds that were too high (see Section 6.6, below, on relations with other services/professionals). It is clear that GPs would prefer a model of referral that allows more stages of consideration, discussion and consultation than currently exists in UK policy before ‘raising concerns’ and making a referral.

Polnay (2001) suggested that, as the thresholds for social work intervention increase, a greater responsibility would rest with the primary health care team to safeguard children, echoed by Key Stakeholders in this study. This relates clearly to the issue of where GPs see themselves on the continuum – promotion of well-being, prevention, protection and management of cases – and whether GPs have the capacity to take a more active role at all stages. Since 2001 the *Every Child Matters Change for Children Programme*, and the National Service Framework, would also include schools and other children’s services as having responsibilities for a child’s overall wellbeing and safety. Varying perceptions of threshold in difficult cases is an issue for any professional working with professionally stressful assessments and is likely to be a cause of significant stress and tension between individuals/professionals (Cooper et al. 2003).

Training

All the professional study participants recognized the impact of training for increasing awareness (the ‘Sentinel’ role), changing practice and improving GP referral rates (the ‘Gatekeeper’/’Gateway’ role), information sharing (the ‘Gatekeeper’ role) and engagement with child protection processes and teams (‘Multi-agency Team Player’ role). Key Stakeholders in this study reported an increase in GP referrals and engagement in the child protection process following training, except for attendance at case conferences. This is clearly reflected in the replies from the GPs who responded to the questionnaires. Sustained levels of referral and awareness over a longer time would need further evidence (Baverstock et al 2008).

GPs involved in this study were interested in child protection, and most of those interviewed had held specialist roles in relation to safeguarding children. Despite this, and Lord Laming's recommendation on training (2003), only 54 of the 96 GP questionnaire respondents had received any training in this field since 2003, with half of these taking part in multi-agency events, and just under two thirds experiencing training provided for health professionals only. This may reflect the difficulty that GPs face in prioritising the opportunity of accessing training alongside other professionals when this needs to be integrated with other priorities and practice.

The identification of separate roles allows the context within which training occurs to be staged and presented differently. The role of 'Case holder' would appear to be integral to existing practice and training as a GP. The roles of 'Sentinel' and 'Gatekeeper'/'Gateway' can be presented as integral to GP practice, and training may be more effective and consistent with the preferences of the GPs when it is convenient, short, and restricted to health professionals (see also: Bannon et al. 2001, Lupton 2001 and Keys 2005). Until this level of awareness required for these roles is achieved, the benefits of multi-agency training for a more proactive role as a 'Multi-agency Team Player' are unlikely to be accepted by participants.

KEY FINDINGS:

Although GPs are clear about 'what to do' when the situation is clear cut for child protection referrals to children's social care services, if it is more complicated, they would seek advice and support from a paediatrician or health visitor first.

Varying perceptions of threshold in difficult cases continues to be an issue for professionals working with stressful assessments and is likely to be a cause of significant stress, tension and loss of trust between individuals/professionals.

GPs on the whole would prefer a model of referral that allows more stages of consideration, discussion and consultation before 'raising concerns'.

6.6 THE GP RELATIONSHIP WITH OTHER CHILDREN'S SERVICES

GPs' relations with other professionals (in a 'Multi-disciplinary Team Player' role) are affected by many factors and barriers to good interprofessional/inter-agency collaboration and communication, as cited frequently in child fatality enquiries and the literature (Stevenson 1989, Hallett 1995). Primary Health Care Teams have traditionally provided the opportunity for health visitors and other practice staff to share with GPs in child safeguarding roles. Changes occurring in structures current at the time of the study have not yet been fully implemented. The experiences reported by the GP participants in the study reflect they have varying views of other professionals, depending on whether they are inside or outside the GP zone of confidence, which rests primarily with health colleagues, who share a similar frame of reference and models of working as GPs.

The responses to the GP questionnaire in relation to parental factors and child presentation also revealed that GPs who are engaged with child protection see a clear gradation of reaction to particular issues linked to the involvement of other professionals. This progresses from discussion with the relevant individuals themselves, referral of the case to another health worker (often a health visitor) and then referral to children's social care services. Responses from GPs (and other participants) in relation to other professionals discussed in this section clearly drew on actual experiences, both positive and negative.

Relations with health visitors

The significance of the role of the health visitor and their expertise has already been noted in Section 6.4 on expectations, and in sources of advice for GPs (Section 6.5).

GPs expressed concern about the decline in the number of health visitors and changes in their role/location, which left some GPs feeling that they no longer had a personal face-to-face relationship with their health visitor. The number of health visitors has fallen to its lowest level since 1994 (NHS Workforce statistics 2007) and, with many due to retire in the next few years and a fall of 40% in training places in England for 2006/7, it would appear that health visiting will be a much reduced service (*Who Cares Briefing Paper* 2007).

The review of the role of the health visitor (DH 2007) recognises that health visitors are highly valued by families and that significant aspects of their role in child health promotion and safeguarding are preventative, and supportive of the most vulnerable families. The review notes that the service is at a crossroads, with other professionals having differing expectations of health visitors and a need for the profession to negotiate how to deliver its core services in the future. This position resonates with some of the same issues facing GPs in their future roles (RCGP 2007). The state of the ongoing and future relationship between health visitors and GPs is highly significant for safeguarding children.

Relations with children's social care services

After the doctor/patient relationship, the second most important concern for a quarter of GPs responding to the questionnaires focused on dissatisfaction with referral processes to children's social care services (especially through contact centres) and lack of feedback after referral. Not receiving feedback from children's social care services was noted specifically by 10/14 of the GPs interviewed as significant. This created a sense of distrust in the child protection services, and, together with threshold perception discrepancies discussed earlier, led GPs where issues were less clear cut, to be more cautious about referring children. GPs interviewed expressed fears about potential problems if they referred to children's social care services, such as losing control of the process or losing contact with families affected negatively by intervention, which was vital to the GP's long term family relationships.

Where the GPs in the interviews identified that a child was at risk, they appeared to be quite decisive as to the action they would take and did not seem preoccupied about a decision to make a child protection referral. The lack of confidence in children's social care services to respond consistently to concerns about the welfare of a child created for the GPs in this study a sense of distrust in the child protection system, which they felt did not work well. The interviewed GPs who expressed dissatisfaction with the lack of feedback particularly when they had made referrals or had been asked for information about a child and parent under s47 Children Act 1989, 2004, were almost certainly biased towards participation in child safeguarding, suggesting that other GPs may have even less engagement with children's social care services.

Key Stakeholders within children's social care services acknowledged that there was insufficient timely feedback and stated that this was due to inadequate resources, including time, when tasks have to be prioritized. This mirrored the explanation given by both Key Stakeholders and GPs, as to why GPs were unable to engage fully in the child protection process (see Section 6.8, below on time/workload constraints).

The need to make referrals through a central contact centre and the lack of opportunity to speak to a social worker at first contact seems to downplay the importance of clear access to the front line service – one of Lord Laming's recommendations (2003). The difficulties cited by many of the GPs in consulting and discussing cases with social workers were in contrast to the range of formal procedures and protocols identified in the literature to facilitate discussion and information sharing, as an aid to decision making (see *Working Together to Safeguard Children*, 1999, 2006).

Both GPs and Key Stakeholders interviewed were aware that the presentation of the referral could influence whether there was a response from children's social care services, with s47 referrals (children at risk) receiving a higher priority than s17 referrals (children in need), which in turn received more attention than a more general referral for services (Children Act 1989). This knowledge was used by at least one GP to redefine the referral in order to access a response. This has implications for the recording of referrals, management of children's social care services' resources and the possible effectiveness of the desired policy shift from protection to prevention.

Relations with other agencies and the multi-professional context

Few GPs in the interviews commented on schools and school nurses. However one GP suggested that schools were the agency best placed to safeguard children, as children were seen in this environment on a daily basis. Three GPs mentioned that they would contact the school nurse, if the child was of school age, but made comments suggesting that a shortage of school nurses, with many school nurses having responsibility for several schools, meant that this was not seen as a prominent source of support for children at risk.

Uncertainty regarding the most appropriate decisions to take in situations where children may be at risk is increased where there is mistrust regarding the response to

referrals from other colleagues, whether health (for example, health visitors) or social care professionals. Some Key Stakeholders felt that GPs had poor relationships with the police and education as well as with children's social care services. Others noted that in their experience, GPs do not see themselves as part of the partnership working to safeguard children, and suggested that the lack of a relationship with other professionals added to their isolation and reluctance to get involved. While Key Stakeholders were aware of the same conflicts of interest as identified by the GPs, seven felt GPs in their PCTs managed this issue by not engaging fully in the inter professional safeguarding agenda.

Some GPs in this study stated that they felt their role was misunderstood by other professionals and felt this affected both their ability to be a key player in the inter agency network and others' perception of their limited engagement. This misunderstanding may potentially compound, or be compounded by, a lack of trust and of an integrated agenda to work together in the best interests of the child. This study raised questions as to how to improve effective inter-agency collaboration within such a climate of limited trust.

Attendance at case conferences (as an example of the 'Multi-disciplinary Team Player' role)

Most Key Stakeholders had definite expectations that GPs would attend child protection conferences, seen as an aspect of being a 'Multi-agency Team Player', which were seldom realized. GPs cited reasons of time, inconvenience and distance, as reasons for their non-attendance, but also questioned whether their contribution was different from that of others, affirming their view that their best contribution was in the identification stage of concerns, and suggesting other health professionals might be more informed at conferences or when writing reports. Only nine of the 44 GPs completing questionnaires who had been invited to attend a case conference in the last year attended, with six of these writing a report as well. 25 of the 35 non-attenders sent reports (fulfilling the 'Gatekeeper'/'Gateway' role). Only a third of Key Stakeholders had seen reports, but these were considered, in their view, of mixed length and quality (cf. Laming 2003).

No distinction is made in the guidance between the importance of GP involvement in initial and review conferences, and several GPs felt that they often had little more to

contribute to review meetings. The suggestion by some GPs in the study, that GPs would attend conferences arranged in the lunch hour or at times to suit them, appears to go against previous research (Hallett 1995; Polnay 2000). GPs who work within a finely structured work schedule are unlikely to be able to allocate two to three hours to attend a case conference.

Barriers to engagement for GPs in multi-disciplinary child protection case conferences are linked therefore to the patterns of practice, but also relate to perception of the value of their own input and to concerns about potential conflicts of interest. In the latter case, avoidance may be a more likely result. Limited personal relationships, due to difficult geographical locations and referral systems, have significantly affected the interpersonal as well as professional relationships for some of the GPs in this study.

KEY FINDINGS:

GPs' lack of confidence in responses from child protection services: not being able to speak directly to social workers in children's social care services, over or under response to concerns, lack of feedback when referrals were made, and the potential impact on families of intervention, were cited as reasons for hesitance in referral and for dilemmas in confidentiality.

The important role of the health visitor in safeguarding children for parents, and as a key fellow professional for the GP to refer to, was confirmed in this study.

GPs in the study reported low attendance at case conferences though provision of reports was higher than expected, and some suggested conferences might be better informed by other/health professionals who may hold more relevant information.

6.7 INFORMATION SHARING, CONFIDENTIALITY AND CONSENT

Decisions concerning the sharing of information are a critical aspect of the 'Gatekeeper' role.

Confidentiality is still a key issue of concern for GPs, although in general practice, managing patient assessment and confidentiality are daily activities, and GPs experienced minimal confidentiality issues sharing information with health colleagues (e.g. seeking advice routes as previously discussed), where the need for explicit parental consent was avoided.. The literature review suggested that information sharing has always been recognized as problematic in practice (Reder & Duncan 2003).

A quarter of the GPs in this study accepted the need to share information to safeguard a child and approached this within their professional guidelines on confidentiality, if it was 'proportionate' to the issue and on a 'need to know' basis. Half the GPs in the questionnaires indicated that confidentiality and seeking consent were constraints when dealing with a child at risk. Despite increasing guidance on this aspect, the majority of GPs interviewed reported difficulties in sharing information with particular agencies, such as children's social care services, which related to trust (Cooper et al 2003). GPs expressed concerns about how and why they were asked for information, the management of third party information and the lack of shared information and reciprocal discussion with children's social care services. There is evidence to suggest that some aspects of difficulty are related to the level of trust between GPs and other agencies, in particular children's social care services (Cooper et al 2003).

Difficulties in information sharing may link to GPs' variable knowledge of child abuse and child protection procedures, and their relationship with the family and other third parties (Murphy 2004, Reder and Duncan 2004). Some Key Stakeholders and GPs suggested that seeking consent to share information was less of an issue in practice for GPs than anticipated. The Key Stakeholders representing the police expressed some concerns that GPs often took a fairly narrow view of information sharing and needed to be more aware of the wider public interest (BMA 2004). This

reflected the view of Berger (2005), that the individual patient's versus the public interest was a potential conflict in decision making for the GP.

All three Focus Groups expected GPs to keep confidentiality, and, while they expected their GP to respect this, they understood and supported the circumstances where there could and should be disclosure, e.g. if a person with mental illness was putting themselves or others at risk or a child was being abused. If there were child protection concerns, the Groups could not see that a GP need feel a conflict of interest between the parent and the child at risk. However, GPs sharing information with other agencies outside the health context, such as with children's social care services, was felt to be stigmatizing and generated fears of consequences, in particular for an innocent parent if wrong decisions were made.

The parents' and young people's Focus Groups preferred GPs to contact health visitors first, and only if that did not work, should the GP contact children's social care services, thus raising the perception that the 'Sentinel' and 'Gatekeeper' roles are still constrained if GPs take account of these parent views. The younger participants, in particular, placed great emphasis on the GP discussing concerns and seeking consent to share information with other agencies. This concurs with the findings of the GMC consultation as to when it is appropriate for doctors to share information without the consent of children and young people (Citizens Jury, Jan 2006) and the subsequent GMC guidance (2007). The Delphi panel emphasized the importance of forewarning parents/families as to the limits of confidentiality and the potential need for referral to other agencies and, along with Key Stakeholders, acknowledged that gaining consent to information sharing was the best way to achieve cooperation and work in partnership with families to safeguard children as argued by Munro (2002).

It is noteworthy that information sharing is essential for the development of GP expertise in safeguarding decisions. Where there is absence of feedback and discussion, this can act as a barrier to reflection and learning about whether concerns, referral and subsequent actions are justified, and whether this knowledge can be applied in subsequent new situations wherever a GP has concerns about a child.

KEY FINDING:

GPs routinely manage patient assessment and confidentiality and experienced minimal confidentiality issues sharing information with health colleagues; confidentiality and seeking consent were constraints when dealing with a child at risk. Parents and young people preferred GPs to contact health visitors first, fearing consequences and stigma from children's social care services.

6.8 THE FRAMEWORK FOR PROVIDING GP SERVICES

The GP Contract and Quality and Outcomes Framework

The study found that for some GPs, there is still a considerable problem in keeping up to date with child protection/safeguarding children arrangements and expectations, along with all the other areas of medicine/GP practice "business". The New GP Contract (BMA 2003) and the Quality and Outcomes Framework (QOF) introduced in 2004 identified specific services, priorities and systems of reward. GPs in the study commented that indicators for safeguarding children in the GP contract (BMA 2003/8) and the QOF appear less than for other areas of GP practice, suggesting a (possibly unintended) lower prioritization by government of these aspects of care. Bland (BMA, 2008) noted reportedly positive improvements in consistency and quality of care for the management of specific long term conditions highlighted for specific attention within the new contract. Future priorities may also change, for example, in obesity, and mental health (BMA 2008) and with the roll out of practice-based commissioning from 2008/9 (DH 2004b).

Some GPs made specific suggestions about making child protection training and templates for significant event analysis linked to QOF indicators. Two thirds of the GPs (10) interviewed thought making child protection training a Quality & Outcomes Framework (QOF) "education indicator" would have a significant effect on attendance at training. One GP specifically suggested that a QOF template for children to be used by PCTs might focus attention on vulnerable children. This may, however, raise further conflicts of interest in terms of the allocation and prioritization of their time.

One GP involved in the pilot study commented that child protection work outside normal surgery work, such as attendance at case conferences, should be remunerated in line with other similar doctors' duties for social care services, such as assessments under the Mental Health Act 1983.

Time and Workload Constraints, Pressures and Priorities

The GP model of practice has highlighted wider tensions for GPs in terms of their funding arrangements, workload and time pressures (GP Contract, BMA 2004). Within these constraints, some professional Key Stakeholders' comments on GPs reflect a view that the conflictual and risky nature of child protection is unlikely to encourage GPs to engage in the safeguarding process or to give it priority.

Nearly all of the participants in the study noted that GPs faced many competing demands on their time. Time factors were cited by 30/96 GPs in questionnaires as affecting attendance at child protection training or case conferences as well as consultation time for addressing difficult issues. While there was an acknowledgement that child protection will have a different priority for professionals in different agencies, several Key Stakeholders commented that GPs are not alone in having high workloads and competing demands on their time.

While almost all GPs cited the short consultation time and pattern of work as a barrier for them in devoting more time for conference attendance and training, even if there are concerns about a child's welfare, they said they would have no hesitation in giving extra time in a consultation when they had such concerns, as they would to any other patient. All the Focus Groups felt that the consultation period was often too short to address problems or take into account communication difficulties. However the three participants who praised their GP specifically commented on their appreciation at being given as much time as they needed, regardless of the other patients waiting.

If GPs are to have the key role in safeguarding children that the government and many other professionals accord them, then this may need to be supported by government initiatives to help GPs prioritise child protection work in line with the RCGP recommendations on raising the profile of child safeguarding (RCGP 2005).

KEY FINDING:

GPs' perception that child protection work goes largely unrecognized may give the message that it is not as valued as other GP activities rewarded under the Quality and Outcomes Framework.

6.9 FORGOTTEN OR INVISIBLE CHILDREN?

The Interests and Voice of the Child

The child is the focus of the safeguarding policy, and *Every Child Matters* (DfES 2003) sets out clearly the five key outcomes for all children: 'being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well being'. The principle that the child's needs are paramount was accepted by all sample groups involved in the study as a solution to any conflicts arising, but there appeared to be little exploration as to what this meant in practice. At times, GPs and other professionals appeared to be more preoccupied with potential professional conflicts and their relationship with the parents, than with communicating with the child. An unexpected finding of this study was the lack of reference by most of the GPs (and Key Stakeholders) to the views and wishes of children, suggesting more work is needed to improve communication and children's involvement in decisions. The findings of the study from the GP questionnaires and interviews provided little evidence that children are talked to and listened to in contexts where their needs can be identified and addressed. Only three of the GPs interviewed commented on their engagement with the child. A few examples were provided in interviews where GPs or other professionals were confident about working with children in practice.

Communicating directly with children as people with wishes and feelings appeared to be easily forgotten in the safeguarding process, and in GP consultations, as noted by the Focus Groups in this study. Cooper et al (2003) also identify this as a key concern and attempt to address this in their proposed model for a child protection system. Laming (2008) commented five years on from the Climbié Inquiry that "*child protection agencies still ignore the child's interests, tending to focus on adults*". The

process can become too adult focused and once started, may prove more traumatic than the abuse itself. If the voice of the child is to be ‘heard’ independently from the voice of the parent/carer then developing confidence in this skill would appear to be central. Addressing communication issues could be assisted by developments (since this study was initiated) in the RCGP Toolkit (2007) and parallel studies within the Safeguarding initiative on long term outcomes for children.

Issues for Children from Black and/or Minority Ethnic Families

Issues concerning the needs of children from black and/or minority ethnic families (and/or with a disability), were seldom identified, despite their prominence in child protection and welfare statistics. The GPs appeared to have limited experience of safeguarding issues affecting children from black and/or minority ethnic families. It was not clear whether GPs lacked awareness of specific issues, or whether it was simply that they had not come across them. Three Key Stakeholders, including two participants from ethnic minority groups, felt that there was a lack of awareness by all professionals of safeguarding issues for black and/or minority ethnic children. It was also suggested that there was a distinction between the attention given to British born children in ethnic minority groups, and those coming into the country, legitimately, from ethnic minority groups, or as asylum seekers or trafficked children. For the latter group, some of the Key Stakeholders felt that the GP should play a key role with these potentially “invisible” children.

Language and communication difficulties were noted by some of the GPs, the South Korean Focus Group, and the Delphi panel. The availability of professional interpreters, cultural issues, power and family dynamics were seen to be issues, which could make it difficult for a GP to identify whether there are any concerns about the child’s welfare. Where there were language difficulties, the impact on consultation time and the GP’s ability to accommodate this has been noted. This could mean that:

- the ‘Sentinel’ role for GPs might not be fulfilled easily under these circumstances;
- the needs of different language communities will be hard to meet, and that
- cultural factors might be overlooked.

BMA guidance (2004) clearly states GPs should be trained in cultural sensitivity (but not language skills). It has also been noted that there is over-representation generally of children from black and/or minority ethnic families among children 'looked after' under child care legislation and in child protection registers, which would be even more remarkable if the under-reporting of child abuse cases was accurate (cf. Creighton & Tissier 2003; RCGP 2005). 'Cultural factors' were recorded as of low concern to GPs who returned questionnaires. The Korean Focus Group highlighted for their community the significance of shame in their culture that might be an important aspect to explore further in relation to safeguarding children. For children from black and/or minority ethnic families, socio-cultural issues across the spectrum of physical, emotional, and sexual abuse and neglect may be particularly complex.

The safeguarding needs of children from ethnic minority groups would merit further study to explore in more depth the specific issues for children from these backgrounds.

Issues for Children with Disabilities

The GPs' discussion of the issues for children with disability appeared generally limited, and GPs reported that children with a disability were more likely to be supported by the community paediatric team and would only attend the surgery for acute events, where they were likely to be seen by which ever GP was available. Key Stakeholders felt GP awareness and knowledge of safeguarding issues for children with disability was variable and often appeared medicalized. The potential vulnerability of children with a disability, physical or learning, to child abuse and neglect is noted in *Working Together to Safeguard Children* (11.27, DfES 2006) because of impaired capacity and communication difficulties. Key Stakeholders commented that child protection training was designed to raise awareness of the special needs of children with disabilities and suggested that, where GPs had attended this training, this had been achieved.

The needs of children with disability is an area that would benefit from further research, particularly in the light of literature highlighting the particular vulnerability of children with disability (NSPCC 2003).

GPs and other agencies would benefit from an increased awareness of the extra vulnerability of all these groups of children, which could be compounded if disabled and from an ethnic minority; specialist training or allocation to specially experienced individuals within primary health care teams might be needed.

KEY FINDINGS:

An unexpected finding of the study was the lack of reference by most of the GPs (and Key Stakeholders) to the views and wishes of children, suggesting more work is needed to improve communication and children's involvement in decisions.

Issues concerning the needs of children with a disability and/or from black and minority ethnic families were seldom identified.

6.10 BEST PRACTICES FOR MANAGING TENSIONS AND CONFLICTS

The GP interviews provided many examples from their own practice in managing child protection concerns, conflicts and tensions. Key features of and strategies for good practice were identified by participants across the study: GPs and Focus Groups, and specific strategies emerging from the Delphi responses to vignette cases.

For GPs: examples of good GP practice emerging from the GP interviews, Delphi Panel and Focus Groups in managing child protection concerns, conflicts and tensions:

- Talking to parents and to children about concerns and involving them in decisions to share information even where this may prove difficult; showing the ability (and making the opportunity) to listen to patients
- Making clear or forewarning parents early of the limits to confidentiality
- Taking time to make an assessment, reassure, consider a response
- Arranging for follow up
- Allocating separate GPs to parent and child/children if there was felt to be a conflict of interest

- Sharing worries with other colleagues, and engaging in significant event analysis
- Developing a consultative, reflective space prior to referral, utilizing the skills of named and designated professionals, paediatricians, and training and case discussion in the practice
- Carefully recording decisions and justifications
- Ensuring that assessments (of the child or the parent) and records of common data were maintained for all relevant members of the family
- Keeping the long term view and allowing the family/relationship time to adjust and recover from difficult decisions.

For LSCBs: features identified by Key Stakeholders as promoting good interprofessional working:

- Ensuring a sense of shared ownership and locally developed protocols
- Agreed and common goals
- Regular face-to-face contact reinforcing personal knowledge and regard
- A reasonably sized area
- Clear allocation and expectation of roles
- Involving GPs in locally negotiated and shared discussion, protocols and guidance.

For children's social care services: as commented by GPs:

- Improvements in feedback from GP referrals could positively encourage recording of concerns and referral rates from GPs.

In relation to good arrangements that promoted opportunities for sharing work with families, several GPs favoured attachment of social workers to GP practices and renewal of health visitor links – these were also seen as appropriately qualified staff to talk directly to children and repeatedly seen as key in coordinating safeguarding concerns. The establishment of Local Safeguarding Children Boards coincided with the beginning of the project and it was clear that these have a role to play in defining local protocols and good interprofessional working practice. The size of area and the achievement of a good partnership were seen as strongly linked; some key

stakeholders in the larger of the two PCTs felt that excessive size was affecting the effectiveness and manageability of LSCBs. Preliminary research undertaken as background to this study identified pockets of excellence in inter professional working and team ownership in delivering practice models consistent with Every Child Matters (e.g. Telford, Shropshire, Cornwall and Harrow). At the time of the study, GPs' participation in LSCBs was limited to Named and Designated Doctors where they existed, and ways of engaging GPs more generally were still developing.

6.11 LIMITATIONS AND STRENGTHS OF THE STUDY

Limitations

Factors that constrain generalization beyond this study include :

- the exploratory and descriptive nature of the research
- the number of case study sites and response rate for the GP questionnaires and interviews
- the context of continuing change in policy and service structures.

The project was restricted to two PCTs, selected to have distinct demographic characteristics, with markedly different numbers of children on the child protection register at the time. Though it was anticipated from the outset that there would be challenges in gaining a response from GPs, the final total of 96/540 represented an average of 18% over the three access areas, despite using a variety of strategies to enhance completion rates and numbers of questionnaires, including accessing additional GP training events across England.

Integrating qualitative data across a range of methods and subjects has natural limitations in managing the integration and identifying commonalities with key terms used. For example, references to ‘GPs’ may be used in relation to *all* GPs, the *GPs in one PCT*, the *GPs known to a service user*, etc.; in general, however, this has proved unproblematic. Almost all the subjects in the study based their comments on the outgoing framework of child protection (prior to the Children Act 2004) and used terms associated with structures at that time.

The timing of data collection coincided with a period of considerable change in policy, structures and terminology. For GPs responding in the study, health visitors were then more highly integrated in GP practices and LSCBs just developing, though in one of the PCTs, local LSCB policies were well established.

Further research would be needed to draw out more detailed analysis on a wider scale and to review the impact of more recent changes and developments.

Strengths

Key strengths of the study include:

- the range of professional perspectives explored through different methods;
- the inclusion of views of parents/carers, young people and ethnic minorities (though it was not possible to access patient groups in the PCTs);
- additional access to senior and well informed child care and health specialist expertise through the Steering group.

The study integrated a range of approaches, to identify factors reported as significant by individual GPs in questionnaires and interviews and to contrast these using other sources and perspectives. The data from the GP questionnaires was sufficiently rich to establish non-random patterns or variation (e.g. in responding to risk factors in parental characteristics and child behaviour), which could then be explored in more detail with the subsample of GPs who agreed to be interviewed. Those interviewed were geographically spread and well qualified, and contributed examples from their own experience. GPs who participated in the study are likely to have a particular interest in this field, and they serve as a reference point for comparison with other perspectives. If the tensions that they face cannot be resolved, then it is likely that the majority of other GPs will find engaging in safeguarding processes difficult.

The researchers interviewed 19 Key Stakeholders (eight professionals from each PCT, and three people representing ethnic minority and disability interests). These interviews could be contrasted with the opinions expressed in the parents' and young people's Focus Groups, allowing the juxtaposition of views of professionals and those of service users, who included young people previously 'looked after' by Local Authority children's social care services. Caution however needs to be taken in treating their opinions as representative, though a number of consistent views was established across the groups,

The Delphi panel drew on a geographically spread group of 25 independent and highly qualified people and provided a balanced, multi-professional perspective on key issues and GPs' expected responses to vignettes. The data generated should be informative in the development of additional materials to improve inter-agency collaboration.

SECTION 7

Summary of Study and Implications for Practice and Policy

7.1 CONTEXT AND SUMMARY OF STUDY

This exploratory research has raised many issues that would be worthy of further study, despite the limitations of the GP response rate and the preliminary and descriptive nature of the findings, drawing on the views of the study participants. .

The study was conducted during the period May 2006 to October 2008, and the substantive period of data collection occurred between October 2006 and June 2007 using two PCTs – one a shire county and one based in South London) as the primary locus for the study.

The initial focus of this research was to investigate potential ‘conflicts of interest’ where parents and children were both patients of the GP, drawing on a multi-professional perspective (including that of GPs) and a service user/parent perspective, and to identify strategies for managing these conflicts. In the early stages of the research it became clear, from both the views of the GPs who participated in the study and the other professionals involved, that such a narrow focus would fail to reflect the relationships between these conflicts and a wider range of tensions. If these relationships were not understood, then any attempt to resolve specific issues regarding ‘conflicts of interest’ would be unlikely to lead to a closer integration of GPs in the wider process of safeguarding children. In order to accommodate this, the purpose of the research was broadened in order to explore and understand the range of conflicts of interest and tensions that might constrain the participation and engagement of GPs in safeguarding children and child protection processes. It was clear that wider policies to integrate services in order to support early intervention might be difficult to achieve in the light of such conflicts.

The study highlighted the complex web of professional issues and tensions for GPs in safeguarding, which go beyond conflicting interests and competing priorities for the child, their parent and the family. The study findings are consistent with much of previous literature and research on multi-professional relationships and the GP contribution to identification of children at risk or neglected. GPs in the study had no difficulty in retaining the interests of children as paramount. However, the study identified that managing expectations of GP participation in early assessment, intervention and multi-professional

support for families would benefit from greater clarification and disaggregation of their role at each stage in the process.

The views of GPs were surveyed by questionnaire ($n = 96$) in the first instance, with 14 agreeing to a follow up interview. These 14 GPs would appear to be highly committed to children's issues and many already had leading roles in safeguarding children (e.g. named doctor, paediatric experience, practice lead role for child protection). All GPs participating were self-selecting. Although it is not possible to assess the views of those GPs who chose not to participate, it seems safe to assume that their non-participation represents a lesser interest in this area of work relative to their other work as GPs.

The views of key stakeholders (professionals linked to the LSCBs in the PCTs and representatives of minority interests) were collected by interview and a Delphi Panel was used to provide an integrated consensus view from a broad range of professionals and 'expert users'. Three focus groups were also used to reflect the views of specific groups of service users: young mothers, a non-white community and young people who had already had experience of support from Local Authority children's social care services.

7.2 SUMMARY OF KEY FINDINGS

1. Expectations of GPs as set out in Government policy documents were not fully shared by GPs themselves and other stakeholders. GPs interviewed saw their role in most cases as referring patients/families on where concerns were raised, while key stakeholders expected fuller engagement in all stages of child protection processes.
2. GPs see supporting parents as the best way to support children and families; all study participants agreed that where serious harm or the likelihood of harm was evident, the child's interests must come first, but keeping the focus on the child was more difficult.
3. Although GPs are clear about 'what to do' when the situation is clear cut for child protection referrals to children's social care services, if it is more complicated, they would seek advice and support from a paediatrician or health visitor first.
4. GPs' lack of confidence in responses from child protection services: not being able to speak directly to social workers in children's social care services, over or under response to concerns, lack of feedback when referrals were made, and the potential impact on families of intervention, were cited as reasons for hesitance in referral and for dilemmas in confidentiality.
5. An unexpected finding of the study was the lack of reference by most of the GPs (and Key Stakeholders) to the views and wishes of children, suggesting more work is needed to improve communication and children's involvement in decisions..
6. The important role of the health visitor in safeguarding children for parents, and as a key fellow professional for the GP to refer to, was confirmed in this study.
7. GPs' perception that child protection work goes largely unrecognized may give the message that it is not as valued as other GP activities rewarded under the Quality and Outcomes Framework.
8. GPs in the study reported low attendance at case conferences though provision of reports was higher than expected, and some suggested conferences might be better informed by other/health professionals who may hold more relevant information.

7.3 COMPARING PERSPECTIVES: GPs' AND OTHER PROFESSIONALS' – KEY MESSAGES FOR POLICY AND PRACTICE

The next sections present a synthesis of key themes emerging from the study which have implications for policy and practice, followed by a number of identified areas for potential further research.

Across the study there was apparent consensus that potential conflicts of interest existed for GPs in taking decisions regarding the safeguarding of children and varying understandings of the range of interests and conflicts, but there was also broad confidence that these could generally be managed. The GPs in the study were clear about the principles and procedures with regard to children who had suffered, or were likely to suffer, significant harm. A similar perspective was expressed by the Key Stakeholders, that conflicts of interest were not irreconcilable, despite complexity, and GPs should not face any difficulty in applying these principles; this view was strongly consistent with the consensus view of the multi-professional Delphi panel. The GPs in the questionnaire showed a consistent pattern in assessing an appropriate response to contextual factors, both in parental background and in child presentation, which indicated that these GPs are engaged with the principles and issues that are embodied in *Every Child Matters*.

Four key differences, however, were noted between GPs' and others' perspectives:

- A significant proportion of the GPs interviewed considered that their role in the safeguarding process was limited to the early identification of cases;
- The threshold levels that might be applied in taking particular decisions were not apparently shared between the GPs and the other professionals;
- The GPs viewed the role of the health visitor (at the time) as more significant than other professionals, and more significant than themselves.
- The significant value placed by these GPs on the doctor/patient relationship with families. This was not reflected in the views of the service users groups, who considered that the health visitor was more supportive of parents and understood children better in most cases. This may be significant for safeguarding children, although the stark contrast is more likely to reflect a different conceptual model

of the doctor/relationship.

Implications for these are discussed below.

Implications for roles and expectations of GPs.

Consideration of the differences above, along with Key Stakeholder comments on the difficulty of interprofessional communication, suggests that the 'role' of GPs should be considered as four separate functional roles, that are distinguished primarily in terms of the impact that a failure to fulfil each function would have on safeguarding children. These have been discussed more fully in Section 6: the 'Case holder', the 'Sentinel', the 'Gatekeeper'/'Gateway', and the 'Multi-agency Team Player' roles.

The current research would suggest that the 'Case holder', 'Sentinel' and 'Gatekeeper'/'Gateway' roles are widely accepted as a professional responsibility that can be integrated with existing professional practice and procedures, and GPs felt most strongly that this was their primary role. The 'Gatekeeper'/'Gateway' role in relation to information sharing would appear to function effectively within the context of health professionals at the moment, but extending this to the wider professional context is where confidentiality dilemmas can arise. The significance of the 'Sentinel' and 'Gatekeeper'/'Gateway' roles will depend on the extent to which the same family (or knowledge) is also known to others (school nurses, health visitors, etc.), but if these roles are left unfilled by any professional, some children or the incidence of child abuse and neglect would remain unseen and the underlying frequency of concerns will remain under-reported.

The roles of 'Gatekeeper'/'Gateway' and 'Multi-agency Team Player' are clearly separated within the guidance framework (Working Together 2006). Where invited to attend case conferences, attendance was relatively high for the GPs in this study (9/44), but remained far below the level of report writing (31/44). In addition, three quarters of those interviewed either attended or wrote reports or did both. This reflects the positive commitment noted above in 7.1 that is atypical of the wider GP population and as represented in the literature but even those interviewed still questioned the value of their contribution compared to other professionals.

The 'Case holder' role is clearly identified by the GPs (90/96) as part of maintaining an ongoing doctor/patient relationship with the family. This acknowledges the responsibility to

the parents 'as patients in their own right' and, in some cases, reflecting the view that supporting the family will often provide the best support for a child's development and wellbeing. This role was however experienced more as a provision of service than as a relationship by the service user/parent groups in this study. The professional Key Stakeholders saw it as valuable but with special responsibilities, a necessary foundation to performing the 'Sentinel' role, but secondary to aspects of accountability, if children need to be protected or supported under child protection procedures. Conflicts of interest between the needs of parents and their children are often represented as confidentiality issues in the context of this role, when action needs to be taken outside the doctor/patient relationship. In order to balance the inter-relationship of interests between a child, parents/carers and his/her family, it appears other professionals think GPs need to refine their adult/child/family focus to reflect the message inherent in the Cabinet Office Social Exclusion Task Force (2007) report *Reaching Out: Think Family*, and, whenever they encounter family issues, keep in mind: *Think Child, Think Family, **Think Child*** and put the child's needs first.

Greater clarification of the nature of roles (as suggested in section 6.4) may be helpful in improving shared understanding. It may also be helpful to:

- Separate out the GP role more clearly in relation to identifying actual and potential causes for concern, referring on and meeting requests for reports and information (for example as in section 6.4).
- Recognize (as evidenced in this study of committed GPs) that GP attendance at case conferences and reports may not necessarily always be appropriate, where another professional in touch with the GP practice holds more relevant information (e.g. the health visitor)
- Differentiate between GP involvement in conferences in the early assessment stage rather than the review stage.

Many GPs expressed the view that their work schedule constrains engagement in key child protection activities outside the surgery, such as training and case conference participation. The perception that child protection work goes largely unrecognised may give the message to many GPs that it is not as valued as other activities receiving a Quality and Outcomes Framework (QOF) component. Improvements to the status of safeguarding as proposed by the RCGP (2005) may well contribute to change in this area of work. Policy makers could

also explore ways of raising the profile of safeguarding work amongst GPs through initiatives that would help GPs prioritise this as core work.

Implications for thresholds, interprofessional relationships and decision-making

Views on thresholds for concern, referral or intervention were not shared across the study participants though there was a shared understanding of the framework for protecting children, and the view that principles should not prevent professionals taking appropriate professional action to keep children safe. This has an important impact on decision-making and consistency of decisions. GPs in this study showed reasonable consistency and confidence in identifying causes for concern, but this may not reflect the consistency of GPs beyond this study or be consistent with the views of other professional groups (as evidenced by Key Stakeholder comment and the literature). Consistency of awareness for the ‘Sentinel’ role among GPs may be best achieved through additional training alongside initial or GP training, or following RCGP recommendations on specialist training (2005, 2007) (i.e. not necessarily multi-professional). Consistency of interpretation and prioritization of child abuse and neglect across and between professional groups for improving integrated interprofessional working could be improved by a number of different strategies:

- Locally negotiated and shared discussion, protocols and guidance (through LSCBs).
- The generation of more empirical evidence to support the correlation of key factors affecting child abuse and neglect (e.g. where linked to parental factors or child development), and to assess the impact of safeguarding action on outcomes for children.
- Training which specifically focuses on ‘Sentinel’ activity to clarify understandings and interpretation of signs and symptoms of child abuse and neglect (currently and most effectively achieved through multi-professional training).
- Development of the consultative, reflective space prior to referral available to GPs, which may build on the skills available from named and designated professionals, links with paediatricians, and in-practice training and case discussion

The use of vignettes for review by GPs as training materials, may be particularly beneficial where considering complex cases and those that challenge threshold decisions about parenting and neglect, and test the expectations of different professionals. This could serve

as an exercise within a GP practice or LSCB building common understandings and recognizing the different contributions of professionals. The GPs' particular contribution to the assessment of neglect over time and for pre-school age children should by this means be positively recognized and developed further alongside other professional expertise.

This study highlighted that GPs do not always feel confident in their relationship with other agencies, most notably children's social care services, but also with schools and the police, when working interprofessionally to safeguard children. The importance of interprofessional collaboration and trust is a long-standing theme and this study confirms that it is an area that still needs attention, particularly as to how to retain and improve interpersonal professional relationships. There was evidence to suggest that other children's services could improve their practice in line with guidance (such as children's social care services providing feedback in relation to referrals).

Once the trials of Contactpoint and the Common Assessment Framework (CAF) (2006, 2007, 2008) are completed, these may provide alternative means to the assessment of need and recording of concerns, where GPs think a child may have additional needs but does not appear to meet the threshold for a child protection referral to children's services. All surgeries would eventually have in place a system for a GP to request that another member of the primary health care team, health visitor or other professional known to the family completes a CAF where appropriate. As this policy becomes embedded in practice, this may help to clarify GP options when safeguarding children at early stages, though this will still be dependent on good interprofessional relations and trust, and on confidence in justifying information sharing and data storage systems.

Implications for the role of health visitors

The role of the health visitor in safeguarding children, and as a key fellow professional for the GP to refer to, was highlighted in this study, and the importance of this role to young parents as a source of advice and support was incontrovertible. The ongoing review of health visitor roles (2007) will need to take account of their new locations, links between new children's trusts and the GP and primary health care team, and the role of school nurses, as part of the evaluation of new structures and taking into account higher expectations of schools for safeguarding school age children.

Summary of Key Messages for policy

- Policy makers could explore ways of raising the profile of safeguarding work amongst GPs through initiatives that would help GPs prioritize this work.
- Future policy guidance might consider strengthening health visitor responsibilities in safeguarding in the light of any location changes away from GP surgeries (e.g. to children's centres), since this study was completed.

7.4 Areas identified for further research and Key Research Messages

The needs of children with a disability and/or from black and/or minority ethnic families, with their prominence in child protection and welfare statistics, would benefit from further exploration beyond this study's findings. The particular needs of asylum and trafficked children appear similarly 'below the radar' and the impact of recent guidance referred to in *Working Together* (2006) on working with immigrant families and the *Trafficking Toolkit* would be useful to evaluate in this context. GPs, along with other agencies, would benefit from an increased awareness of the extra vulnerability of all these groups of children, which might require additional and specific training.

An unexpected finding of this study was the lack of reference by most of the GPs and Key Stakeholders to the views and wishes of children. While there was an awareness that the needs of a child were of paramount importance and had to be separated out from the parents and family, there were only a few examples where GPs or other professionals were confident about achieving this in practice. *Every Child Matters* promotes a child centred approach with its emphasis on local arrangements to support children, through the developing children's trusts and children's centres, but communicating directly with children appears to be frequently forgotten in the safeguarding process and needs more attention. Engaging with vulnerable children and responding to their needs requires skills, which could be developed with specific training or allocated to specially experienced individuals within primary health care teams. Strategies for best practice identified in this study referred to talking to, listening to and involving a child in decisions and gaining their

consent. Further examination as to how to improve GPs' (and other professionals') abilities to engage and communicate with children would need more specific research, to include evaluation of outcomes for children who were involved in decisions about them. This could be assisted by developments (since this study was initiated) in the RCGP Toolkit (2007) and parallel studies within the Safeguarding initiative on long term outcomes for children (DH/DfES 2005).

Summary of Key Messages for research

- Greater clarification of expectations and differentiation of roles expected of GPs might allow exploration of the impact on multi-disciplinary relations, the appropriateness of different professionals' involvement in child protection conferences, and the particular role GPs can play in neglect cases.
- The RCGP strategy (2005) noted the lack of an evidence base for positive outcomes from intervention by GPs in safeguarding cases. Changes in GP templates for child protection conference reports could contribute significantly to establishing an appropriate evidence base of cases and more detailed sets of indicators for identifying concern more confidently (e.g. where linked to parental factors or child development).
- Further research is needed to evaluate outcomes for children who were involved by GPs in decisions about them.
- The needs of children with a disability and/or from black and/or minority ethnic families would benefit from a focused study to include professionals and families from these minority groups.
- Future comparative studies of GPs and LSCBs on a larger scale are likely to be constrained unless data recording in LSCBs is standardized.

7.5 Concluding comments

This multi-perspective study, involving over 100 GPs, 34 other professionals and representatives from parents, young people and ethnic minority and disability groups, highlights the complex web of professional issues faced by the GPs in this study when safeguarding children. The study has explored the tensions that can arise in ensuring that the child's interests are paramount, where the competing interests of the child, their parent and family are all factors to be considered. The evidence suggests that there are still tensions in the understanding and interpretation of the GP role between GPs and other agencies.

The study was conducted within a context of changing policies, structures and guidance. New frameworks, arrangements and relationships emerging since this study was initiated (particularly in relation to health visitors, Contactpoint, and the Common Assessment Framework) will provide a new context in which these tensions can be addressed further. Collaboration with GPs themselves and the RCGP may contribute to resolving tensions and bringing about more effective interagency safeguarding processes and better outcomes for children.

While there is much evidence of the commitment of individual GPs to the welfare of their families and to managing tensions and conflicts that can arise, the study reiterated the need to see the child behind the parent, and to 'Think child, think family,... think child'.

Though restricted in its scope and given the exploratory and descriptive nature of the findings, this study has generated messages that will be relevant for practitioners, organizations and policy makers, identified further areas for research, and provided some examples and suggestions from research participants for best practice in managing tensions and conflicts.

SECTION EIGHT:

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SECTION 9: APPENDICES & METHODS ANNEXES

LIST OF APPENDICES IN DOCUMENT 2

Document	Section
1 GP questionnaire	Methods,
2 Sample GP interview schedule	Methods
3 Key stakeholder interview schedule	Methods
4 Focus group plan and vignettes	Methods
5 Delphi Panel areas of experience and expertise	Methods - Delphi
6 Delphi Vignettes	Methods - Delphi
7 Detailed overview of Delphi process	Methods - Delphi
8 Response rates to Delphi Process	Methods - Delphi
9 The Panel's understanding of 'conflicts of interests' in the context of safeguarding children	Delphi Findings
10 Principles that should guide a GP when conflicts of interests occur in the safeguarding of children.	Delphi Findings
11 Vignette statements removed (less than 75% consensus)	Delphi Findings
12 How should the GP respond in relation to each of the vignettes?	Delphi Findings
13 GP responses and timing in relation to vignettes	Delphi Findings
14 Final Round 4 comments from the Panel in relation to the vignettes	Delphi Findings
15 To whom or where should GPs go to for professional advice in relation to conflicts of interests and safeguarding children?	Delphi Findings
16 Additional discussion in relation to vignettes	Delphi Findings
17 Themes relating to principles in relation to general practice, conflicts of interests and safeguarding children	Delphi discussion
18 Details of participants of Delphi panel who wished to be acknowledged	Acknowledgements
19 Developing a Model for Training Purposes: Understanding GPs' roles in safeguarding children	Conclusions

Methods Annexes

Annex 1: The Delphi Methodology

The Delphi method is a means of obtaining a consensus of expert opinion in relation to complex problems. Sackman (1975 p. xi) describes it as:

an attempt to elicit expert opinion in a systematic manner for useful results. It usually involves iterative questioning administered to individual experts in a manner protecting the anonymity of their responses. Feedback of results accompanies each iteration of the questionnaire, which continues until convergence of opinion, or a point of diminishing returns, is reached. The end product is the consensus of experts, on each of the questionnaire items...

Early studies used the Delphi technique for scientific and technological forecasting (Sackman 1974, 'Project Rand'); In addition it has had other applications, for example, evaluation, planning, priority sorting, policy making, formulating good practice and good practice models (Powell, 2003, Gabb et al 2006). The technique is relevant where accurate information is expensive or difficult to obtain and where the subjective responses of experts can illuminate areas of uncertainty (Linstone and Turoff 1975). It can be an effective and efficient means of establishing the degree of consensus between different experts, and has been used in this study to combine the knowledge and values of a wide-ranging panel of experts, in relation to conflicts of interests, safeguarding children and General Practitioners.

The Delphi Panel

The research team set out to create a Panel from those considered to have expertise in safeguarding children issues, for example, those working in health and social care services, education, research and in the voluntary sector. For the purposes of this study, expertise also included both those with relevant formal or professional qualifications and those considered 'expert by experience' (Collins and Evans 2002).

The areas of experience and expertise for the Panel identified as desirable were as follows:

1. Parent/guardian	12. Domestic violence policy
2. Child perspective	13. Human rights
3. Service user (with experience of safeguarding processes)	14. Ethnicity/diversity focus
4. General practice	15. Law
5. Social work	16. Mental health
6. Nursing	17. Drug and alcohol
7. Child Care Research	18. Physical disabilities
8. Education	19. Learning disabilities
9. Police	20. Paediatric practice
10. Child protection/safeguarding children practice	21. Asylum/immigration
11. Child protection/safeguarding children policy	

The panel was constructed through discussions within the research team and with input from the Project Steering/Advisory Group. Individuals were identified by reputation and recommendation across the UK, through personal contacts with people in specific posts or with specific knowledge in the child protection system, or through a snowballing process: one person approached might suggest others who would be suitable.

47 individuals were approached and 27 agreed to participate in the Delphi. Panel members were asked in the round one questionnaire to state their experience and expertise. 2 potential panel members withdrew on receiving the first round. After this, with the exception of the police (Appendix 5, Document 2), there was representation within the 25 participants from all desired areas listed and from a broad geographical spread. In addition, Panel Members also claimed experience or expertise in one, or more, of the following areas:

- Parental mental health
- School governor
- Ethics and professional guidelines development
- Multi-agency working and partnership
- Midwifery issues
- Lecturer medical ethics
- .Co-ordinator of School Social Care Team
- Experience in voluntary sector
- GP tutor
- Practice child protection lead
- Acted for social workers on child death enquiries, advised fostering and adoption

8ii The Delphi Process

The Delphi technique comprised four rounds. In each round a questionnaire was emailed to Panel members. ‘Conflicts of interest’ vignettes were used as a means to focus on dilemmas where conflicts are present, to explore the complexity of situations that might face a GP and to gain panel members’ views. Four different vignettes (Appendix 6, Document 2) were developed by the Research Team, informed by responses from the GP questionnaires, the literature, and discussions within the research team. An initial questionnaire was constructed which was piloted with a small number of GPs and other health and social care professionals.

A detailed overview of the Delphi process is provided in Appendix 7, Document 2. By the end of the process, participants had been asked eight questions relating specifically to conflicts of interests and four questions relating to the four vignettes.

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?
- 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.

In relation to each of the *vignettes*, Panel members were asked to respond to:

- What issues arise?
- How should Dr X respond?
- Why should s/he respond in this way?
- What might make a response difficult?

Statements were generated from the responses and suggestions collated. The team decided to focus on particular areas of the questionnaire and to ask Panel members to provide further responses in relation to the generated statements/suggestions in order to identify areas of consensus. It was agreed, following Powell (2003), that “consensus was (to be) defined as 75% or more of participants agreeing/strongly agreeing” (p 30). 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. Any statement achieving at least 75% agreement at each stage was retained. Statements achieving less than 25% agreement were dropped. Statements achieving less than 75% but greater than 25% agreement were re-

submitted to the Panel for further consideration. A lack of response to a particular statement was treated as non-agreement. Those statements that continued to achieve under 75% agreement were removed from consideration in the next round.

Panel members were asked in the rounds after Round 1 to do the following:

For *Sources of professional advice*: to rate their views of the relative importance of the suggestions.

For *Principles*: to indicate their agreement or disagreement to, and their views of relative importance of the principle statements.

For *Understanding of 'conflicts of interests'* : to indicate their agreement or disagreement to, and their views of relative importance of 'conflicts of interest' statements, and to identify 3 statements that best described conflicts of interest.

Vignettes

In relation to statements *recommending GP responses* in each vignette: Panel members were asked to indicate their agreement or disagreement , views of relative importance and appropriate timings for each response by a GP.

In relation *to each vignette*: they were asked to rate the seriousness or urgency.

The Delphi Findings and Discussion will be presented in the following order: the Panel's *understanding of 'conflicts of interests', principles, sources of professional advice, and vignettes*.

8iv Responses

Response rates to each of the rounds in the Delphi process (Appendix 8, Document 2) were Round 1: 93% (25 responses), Round 2: 72% (18 responses), Round 3: 56% (14 responses) and Round 4: 56% (14 responses) . As has occurred in other Delphi panels, some participants dropped out of intervening rounds and returned responses in the final round. GP Panel Responses in the 4 rounds were as follows: 6 , 4, 2, and 3.

Annex 2: Details of Statistical Tests

Note: where the validity of a null hypothesis would occur $p < 1 \times 10^{-3}$, this is abbreviated as $p \approx 0$.

Test 1.

Null hypothesis: The distribution of children on the child protection register is independent of the PCT in which they are registered.

This is equivalent to a probability of selecting a random set of 60 from a set of 301, without replacement, but a model that is based on 'with replacement' will provide a suitable approximation. In this case the probability of that pattern occurring at random is less 1×10^{-3}

It should be concluded that the incidence of children on the child protection residents varies between the two PCTs. A consequence of this is that discussion about an 'average' number of cases is invalid.

Test 2.

Null hypothesis: The 10 GPs who agreed to be interviewed were randomly selected from the GPs who attended the training sessions (34) and those who were contacted through another mode .

This is equivalent to a probability of selecting a random set of 14 from a set of 96, without replacement, and ending up with a set of 10 or more from a particular subset of 34. Direct calculation of the values for 10::14 gives an upper limit of 0.0036.

It should be concluded that the subset of GPs who agreed to be interviewed was biased to those who had been identified by their attendance at a training session. .

Test 3.

Null hypothesis: Level of response from GPs and parental factors are unrelated.

Levels of response at levels 1 and 2 were grouped to avoid small groups and level 6 was discounted. This gives a 7×4 cell contingency table with a chi-squared value of

209.8 with 18 degrees of freedom. This would occur at random with a probably 1×10^{-3} . This is sufficiently low to reject the null hypothesis.

It should be concluded that the level of response varies systematically with the parental factors.

Test 4.

Null hypothesis: Level of response from GPs and presentation of child are unrelated.

Levels of response at levels 1 and 2 were grouped to avoid small groups and level 6 was discounted. This gives a 7 x 4 cell contingency table with a chi-squared value of 227.3 with 18 degrees of freedom. This would occur at random with a probably 1×10^{-3} . This is sufficiently low to reject the null hypothesis.

It should be concluded that the level of response varies systematically with the presentation of the child.

Annex 3: Analysis of Final Themes emerging across the Study Methods

Method		Themes
1	Questionnaires to GPs	<p>Training for Child Protection</p> <p>GP knowledge, awareness and confidence of child abuse/neglect and procedures</p> <p>Information Sharing & Confidentiality</p> <p>Decision Making & the Child protection process</p> <p>Interprofessional relationships, especially children's social care services</p>
2	Interviews with GPs	<p>Significance of GP role</p> <p>Children from BME</p> <p>Children with Disability</p> <p>Doctor/Patient relationship: Adult Child/Family focus</p> <p>Interests and voice of the child</p> <p>Time Pressures/Case Conference</p> <p>Attendance/Reports</p> <p>GP Contract/priorities</p> <p>Information Sharing & Confidentiality</p> <p>Who to go to for advice</p> <p>Decision Making & the Child protection process</p> <p>Interprofessional relationships especially children's social services, and thresholds for concern/referral</p> <p>Concern re getting it wrong</p> <p>Good Practice: examples from experience</p>
3	Interviews with key stakeholders	<p>Significance of the GP role/Awareness of child protection</p> <p>Children from BME</p> <p>Children with Disability</p> <p>Doctor/Patient relationship: Adult/Child/ Family focus</p> <p>Time Pressures/Case Conference</p> <p>Attendance/Reports</p> <p>Training for child protection/effects</p> <p>Role of Health Visitors</p> <p>Information Sharing & Confidentiality</p> <p>Decision Making & the Child protection process/partnership</p> <p>Thresholds for concern/referral</p> <p>Interprofessional relationships</p> <p>Doctor/patient relationship and impact on decisions</p>

4	Focus Groups with parents/carers and with young people	Significance of the GP role & expectations Role of Health Visitor Children from BME Time pressures Information Sharing & Confidentiality Making judgements/consequences of getting it wrong
5	Delphi discussion	Definitions and principles of Conflicts of Interest Significance of the GP role Who to go to for advice Good practice examples: vignettes