



DfES/DH Research Project

The Child, the Family and the GP:

Tensions and conflicts of interest

in safeguarding children

May 2006 – October 2008

Executive Summary May 2009

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Introduction

This research was undertaken within a context that services are best provided by inter-agency collaboration, yet there was a continuing awareness that “*GPs are accorded, both within government guidance and by fellow professionals, a much more pivotal role in all stages of the child protection process than they typically assume themselves*” (Lupton et al 2001 p177).

The initial focus of this research was to investigate potential ‘conflicts of interest’ where parents and children were both patients of the GP and to identify strategies for managing these conflicts. In response to initial feedback from the piloting of research tools, the focus of the research was broadened to explore and understand the range of conflicts, interests and tensions that might constrain the participation and engagement of GPs in safeguarding children and child protection processes, and the complexity of relationships between GPs, parents and children, and other professionals.

Following the Laming Enquiry and the development of the government’s Every Child Matters policy (2003), subsequent legislation and policy guidance marked a shift from protection to prevention and the promotion of better outcomes for all children. The GP role is defined in documents primarily to identify children felt to be at risk and refer them for appropriate assessment and services, but also includes possible involvement in subsequent intervention (HMG 2006). Their role is largely incorporated within primary health care team duties and responsibilities. There is also considerable profession specific advice to support GPs in their safeguarding role with children, especially concerning confidentiality and their key responsibilities as a GP and a doctor, from the regulatory and professional bodies and Royal Colleges (e.g. GMC, BMA, RCGP, RCPCH, RCP).

Several commentators in the literature cite the ‘unique’ contribution GPs can make to preventive approaches to safeguarding and family work (Bastaple 2005, Leheup 2001), based on their longstanding knowledge of family history, networks and the community, professional stability, open access through self-referral, and respect and regard from many

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parents. Research into the role GPs play in safeguarding children at risk is limited, and has tended to focus more on limited participation in multi disciplinary activities (such as child protection conferences) and discrepancies in their perception of causes for concern.

While the RCGP (2005) have been seeking to integrate child abuse and neglect into the GP core curriculum and responsibilities, there remains a challenge as to how the prioritization of safeguarding is promoted for GPs and evidence gathered about the effectiveness of their intervention.

This research was conducted during the period May 2006 to October 2008, with data collected between October 2006 and June 2007.

Aims and Methods

Aims and Objectives

Drawing on relevant issues for GPs identified by Bastable & Horwath (2004), the study aimed to:

1. Explore the nature and consequences of tensions and conflicts of interest for GPs in safeguarding children taking account of key factors such as:
 - The doctor/patient relationship, considering who is the patient and the balance of family interests versus the child's interests, 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 and responded to 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 to promote best practice and clarify the role of the GP as part of the inter professional response.

Methods

This was an exploratory mixed methods study focusing particularly on GPs in two contrasting Primary Care Trusts (PCTs) in a shire county and South London, and groups of GPs accessed through training events. The research was informed by an extensive review of the literature and policy statements, demographic and child protection data in the two PCTs and five contributory sources including:

- 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, 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.

This study drew on both qualitative and quantitative data. Qualitative data was analyzed through open coding and thematic analysis, both within and then across the separate parts of the study. Where data was quantitative, a range of statistical tests was applied in order to test for/against independence of a number of associations.

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.

Findings

1. Understandings of interests/conflicts of interest and frequency of occurrence for GPs

The word 'interests' covers a range of concepts, such as needs, wants, and rights, in various combinations, and findings from all parts of the study suggested that there are many ways that potential conflicts of interest may arise for those involved (the GP, a child, a parent or carer) and a GP has to balance all these.

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. The literature suggests GPs see around 1-2 child protection cases per year (Lupton et al 2000), but a paediatrician (Key Stakeholder) challenged this notion, suggesting a GP will see risk indicators of child/abuse or neglect in every surgery.

Different levels of awareness, areas of tension and complexity emerged during the course of the study from the different participant views.

2. The Doctor/Patient Relationship: An adult, child or family focus?

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

GPs rated their knowledge of families beyond individual medical information as limited, but the relationship with the patient as important. Both Key Stakeholders and the Delphi panel acknowledged the importance of the doctor/patient relationship but expressed concerns that

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over-confidence in 'knowing' the parent or carer, might lead to misjudgment, over-identification with parents or GPs not seeing concerns about children.

Most Focus Group members experienced the GP consultation as a service not as a relationship; they expressed disappointment when their high expectations of the GP were not always met, especially in terms of relationships rather than roles. They emphasized pragmatic difficulties of access (to the same GP, and time availability) and in contrast, rated health visitors very highly in terms of their child care expertise, accessibility, knowledge of families and the support they gave to parents and children. All 7 young mothers in the Focus Group felt the health visitor knew them and their children better than their GP did.

All Key Stakeholders acknowledged the difficulty in separating out the interests of the child from the parent/family, and adopting a focus on the child rather than on the adult. However, where significant harm or the likelihood of significant harm to the child is evident, then all participants in the study agreed that the child's interests must come first.

3. Expectations of the GP role in safeguarding children.

In relation to safeguarding, GPs in the study emphasized their continuity role with families, a specific and preferred role in early identification of concerns and a limited contribution in multi-agency interventions to protect children at later stages. These perceptions were not shared by Key Stakeholders or consistent with how policy guidelines for GPs on participation in all stages of safeguarding were interpreted by others. Key Stakeholders and Delphi panel members expected GPs to play a significant, ongoing role in all aspects of safeguarding children, and even to take on a more central role, but recognized that this would depend on individual cases.

In integrating the separate parts of the study and analyzing comments made by GPs, Key Stakeholders, Focus Group and Delphi panel members, it proved useful to distinguish four separate roles in safeguarding children that a GP can fulfill, termed here as: the 'Case holder', 'Sentinel', 'Gatekeeper (or 'Gateway)', and the 'Multi-agency Team Player' (see table 1 below).

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Table 1: 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.

The ‘Case holder’ role relates particularly to the doctor/patient relationship. GPs across the study identified distinctive opportunities for themselves and the practice to support their special contribution to families (Bannon and Carter 2002), enabled by: self referral, encouraging voluntary disclosure of problems and development of trust over time; an understanding of a child’s health and developmental progress within their family, and knowledge regarding a parent who is troubled or in difficulties. The majority of GPs interviewed (9/14) saw this role and that of ‘Gatekeeper /Gateway’ as their key responsibility in safeguarding, drawing parallels with everyday practice in healthcare, picking up concerns and referring on to specialist resources/services any clinical problem that was beyond their scope. All but three Key Stakeholders rated the GP’s understanding of families’ situations

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important, and all (19) rated their significance highly especially in neglect cases, where neglect was a process not a single event (Stevenson 2007).

The ‘Sentinel’ role¹ links directly to the description in 2.74, *Working Together to Safeguard Children*, and is dependent on confidence in decision-making and referral. Focus Group members were unsure, as were some Key Stakeholders, of some GPs’ abilities to identify that a child was at risk (in the ‘Sentinel’ role), whereas health visitors knew families well.

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.

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. Study participants, commenting on the significance, role and expectations of the GP contribution to safeguarding, related their comments to roles and absence/presence of other professionals (e.g. health visitor or school nurse), and the age of the child. Where children are not yet attending school, the GP was seen as well placed to fulfill ‘Sentinel’ safeguarding responsibilities, while some GPs thought schools were more likely to be more informed about school age children than the GP practice.

¹ Reflecting the use of sentinels in the sentinel approach to research in estimating the incidence of child abuse in (Sedlack & Broadhurst 1999) and elder abuse in (Geroff & Olshaker 2006).

4. GP confidence in the child protection process and other professionals

All the GPs who completed questionnaires were aware of the child protection procedures and the need to contact children's social care services. Where GPs interviewed identified that a child was at risk and the situation and evidence were clear cut, all expressed no difficulty in coming to a decision to make a child protection referral. 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, reflecting legal requirements and responsibilities, and two thirds reported they had not experienced inadequacies in the child protection procedures.

When considering whether to refer concerns on, GPs in questionnaires related this to a range of parental difficulties and child presentational behaviours. The GP responses 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 concern or referral to children's social care services, with 'alcohol and drug abuse' the next most significant factor for parents. A quarter of GPs would refer a parent with "learning disability" to another health colleague, but GP concerns were least in relation to 'cultural factors' and 'physical disability' in parents. 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 might be involved in any cases where the child or parent appeared in difficulties, especially 'failure to thrive' or 'anxious' or 'withdrawn' behaviour.

Sources of information, advice for decision-making about safeguarding, and where GPs, if they had 'concerns', could refer for expert/specialist consultation were identified in this study. Sources suggested were highly context related, given that structures for safeguarding children were in transition at the time of the study, and arrangements varied markedly between the two PCTs. Half of the GPs expressed a preference for seeking early advice and support from a paediatrician or other health colleague, rather than children's social care services. Two thirds of GPs rated the health visitor as highly significant to refer to, where there was concern for a child. GPs on the whole would prefer a model of referral that allows more stages of consideration, discussion and consultation *before* 'raising concerns'.

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Many GPs sought local solutions with the family, managing child welfare concerns within the primary health care arena, and (in the view of some Key Stakeholders and GPs) would be more likely to delay referral for concerns to children's social care services, where response levels were unpredictable or seemed inappropriate (child protection procedures invoked with "*all guns blazing*" or 'no action'), not always, in their view, in the child's best interests. Key Stakeholders were concerned about thresholds for social work intervention becoming higher, placing a greater responsibility on the primary health care team. Varying perceptions of threshold in difficult cases is well recognized by Cooper et al. (2003) as a cause of significant stress and tension for and between individuals/professionals.

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, 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.

GPs' relations with other professionals were affected by many factors, which they saw as facilitating or hindering interprofessional/inter-agency collaboration and communication. Their view of primary health care teams reflected the context where health visitors and other practice staff traditionally shared safeguarding roles with GPs. Changes anticipated in structures current at the time of the study had not been fully implemented, for example the relocation of health visitors to children's centres, and GPs expressed considerable anxiety about the possible impact of this. Experiences reported by GP participants in the study reflected their varying views of other professionals, depending on whether they were inside or outside the GP's perceived zone of confidence, centred primarily around health colleagues, who share a similar frame of reference, model of working, and approach to scientific knowledge. Interestingly, school nurses were mentioned by only 9/96 GPs, and education Key Stakeholders had limited contact with GPs, both apparently outside the GP zone.

5. Information sharing and confidentiality.

In general practice, managing patient assessment and confidentiality are daily activities, and GPs experienced minimal confidentiality issues sharing information with health colleagues, where the need for explicit parental consent was avoided.

Half the GPs in the questionnaires indicated that confidentiality and seeking consent were constraints when dealing with a child at risk. In the 'Gatekeeper' role, managing this was critical. A quarter of the GPs 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. Despite increasing professional and policy guidance on information sharing, the majority of GPs interviewed reported difficulties in sharing information with particular agencies, such as children's social care services, which related to trust. 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.

Key Stakeholders noted that knowing what to share and seeking consent to share were potentially difficult areas for GPs, though some Key Stakeholders (and GPs) suggested this was less of an issue in practice. Key Stakeholders representing the police expressed some concerns that GPs often took a narrow view of information sharing and needed to be more aware of the wider public interest, as referred to in BMA (2004).

All three Focus Groups expected GPs to keep confidentiality but noted that there were 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.

6. Incentives for safeguarding work and training in the GP service framework

The study found that for some GPs, there was 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”. 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. Only 41 GPs had participated in child protection training since 2003, with the highest proportion among the newly qualified. While ten of the 14 GPs interviewed felt in principle multi agency training was valuable, it was not seen as practical for busy GPs to participate in this. GPs in the questionnaires reported a preference for convenient, short child protection training. This had been more easily achieved for a third by the inclusion of only health professionals; a quarter accessed multi-agency training and 12 GPs accessed both, matching research findings (Weir et al 1997, Bannon et al 2001, Keys 2005).

GPs in the study commented that indicators for safeguarding children in the GP contract (BMA 2003/8) and the Quality and Outcomes Framework (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 commissioning from 2008/9 (DH 2004). Some GPs made specific suggestions about making child protection training and templates for significant event analysis linked to QOF indicators.

7 Forgotten or Invisible Children

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. A few examples were provided in interviews where GPs or other professionals were confident about working with children in practice.

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Communicating directly with children appeared to be easily forgotten in the safeguarding process, and in GP consultations, as noted by the Focus Groups in this study. 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*”. 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 concerning the needs of children with a disability and/or from black and/or minority ethnic families, were seldom identified, despite their prominence in child protection and welfare statistics. GPs and other agencies would benefit from an increased awareness of the extra vulnerability of all these groups of children, which might need specialist training or allocation to specially experienced individuals within primary health care teams.

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.

Conclusion and Implications for Policy, Research and Practice,

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 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, the study has generated messages that will be relevant for policy makers, practitioners and organizations, identified further areas for research, and provided some examples and suggestions from research participants for best practice in managing tensions and conflicts.

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.

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- 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.

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.

Examples and Suggestions for Managing Tensions and Conflicts

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

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- 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
- Agreed and common goals
- Regular face-to-face contact reinforcing personal knowledge and regard
- A reasonably sized area
- 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.

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