Safeguarding Children in Primary Care: A Critical Review of the role of the Prime Worker – Necessity or Luxury?

by

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Statement of Originality

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification.
Title:

*Safeguarding Children in Primary Care: A Critical Review of the role of the Prime Worker – Necessity or Luxury?*
Several thousand years ago, when primal forces haunted imagination, great gods arose in myths to explain the creation of the world. At the beginning was Chaos, the endless, yawning chasm devoid of form or fullness. And there also was Gaia, mother of the earth, she who brought forth form and stability. In Greek story, Chaos and Gaia were partners, two primordial powers engaged in a duet of opposition and resonance, creating everything we know (Wheatley: 115).

This study is dedicated to Pat Hale, Clinical Specialist Child Protection Primary Care (retired) whose support and inspiration as my personal facilitator on a child protection course in 1994-1996 influenced the future direction of my career and who in 1997 led the development of the Prime worker role.

What can streams teach me about organisations? I am attracted to the diversity I see, to these swirling combinations of mud, silt, grass, water and rocks. The stream has an impressive ability to adapt, to change the configurations, to let power shift, to create new structures ... the forms change but the mission remains clear ... organisations lack this kind of faith, faith they can accomplish their purpose in varied ways and that they focus on intent and vision, letting forms emerge and disappear ... if we want progress, then we must provide energy to revise decay (Wheatley: 18).
Abstract

The Laming Report in 2003 criticised organisations including the health service, for what appeared widespread organisational malaise and a failure of good basic practice in respect of safeguarding children.

This study set out to answer the research question of how staff should be supported within primary health care teams in relation to safeguarding children. It sought to gain an organisational perspective on the value of the existing role of a lead professional for child protection and to identify and compare other similar models. The direction for this study stemmed from a Policy Analysis and Service Development Project as precursors to this study and part of a Professional Doctorate programme.

The study took place during 2004-2007 in a PCT in the UK, within a context of prolific organisational and policy change. Q-methodology was selected as the most appropriate way to systematically examine subjective data, illuminate different viewpoints and perceptions, and to 'hear many voices'. This approach allowed apparent chaos of the Prime worker role to be explored in depth through generation of the concourse, the Q-sort and through the discourse generated. A purposive sample for the Q-sort included ten people within the organisation and wider stakeholders who had a key strategic role and influence on child protection. Interviews were undertaken with a Government Policy Advisor and a PCT Director, and an on-line GP discussion group sought to explore different aspects of the findings.

An inductive approach to analysis was undertaken in order to discover factors and themes emerging from the data. Descriptive statistical analysis provided initial data reduction and demonstrated significance in the Sorting. All discourse from the sort process and interviews were taped and transcribed by the researcher to support data immersion. A manual method of coding was employed.

From the themes emerging from this study, a number of building blocks that contribute to the facilitation of child protection systems in primary care have been identified. These include the importance of meta communication (how communication is communicated), the need for the PCT to support GPs in developing their role in safeguarding, the importance of the PCT leading innovation and a consensus as to the value of a lead professional for child protection within primary care (Prime worker). This study also identified concerns about the perceived impact of competing government policy on child protection systems and networks. Recommendations have been made that include the nPCT supporting and developing the Prime worker role in all GP Practices across the County.

The researcher proposes the Q-sort method is a useful and reliable method for liberating opinion in a politically charged area where senior staff may be reluctant to express personal views and subjective opinion.
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Foreword

The period in which this study has been undertaken (2004-2007), is set within a context of constant organisational change within the PCT being studied, the Health Service and for partner Statutory Agencies. A time line has been included within the appendix to highlight these changes and to acknowledge the vast amount of legislation and policy implemented during this period. Working within the field of safeguarding and protecting Children, there is always new literature and research to be incorporated into changing practice. The researcher’s own role has changed three times within the four-year period under study. With PCT reconfiguration in 2006, the PCT being studied in 2004 no longer exists and has merged with four other PCTs to become one nPCT. Of the ten participants from the organisation being studied, by August 2007 only three were still in their roles.

'It is like walking through a maze whose walls rearrange themselves with every step you take' (Gleik 1987:24).
Chapter 1  INTRODUCTION TO STUDY.

1.1  Introduction to chapter

*The extent of the failure to protect Victoria was lamentable. Tragically, it required nothing more than basic good practice being put into operation. This never happened.* (Lord Laming 2003:6).

'Child protection is everyone's responsibility' was a key message from Lord Laming following publication of the report in 2003 into the death of Victoria Climbie. Recommendations were made only too similar to those Inquiries spanning the last 30 years. However, for the first time organisation including the health service were highly criticised for what appeared 'widespread organisational malaise' (Laming 2003:4).

The death of Victoria occurred in a period of constant organisational change within the Health Service. A key theme in this study is how organisations manage constant change yet also have effective systems in place that provide support to staff, and promote and safeguard the welfare of children. This study focuses on child protection support networks within primary care, particularly the role of the Prime worker for child protection.

The importance of effective communication and collaboration at multi-disciplinary single agency levels for those working with children and particularly in child protection is widely acknowledged and extensively documented (Burton 1996, DH¹ 1995, Laming 2003, Lupton et al 2001, Reder et al 1993, Reder and Duncan 2003). Child death inquiries whether dating back to Maria Colwell in the 1970s (DHSS 1974), or Victoria Climbie (Laming 2003) highlight poor communication as a contributory factor. With each inquiry a series of recommendations to improve practice are identified. Following such inquiries, child protection policy, procedures and practice are

¹ For the sake of consistency throughout the study, 'DH' has been used to reference all Department of Health Publications.
evaluated and modified. 'Working Together to Safeguard Children' (HM Government 2006) provides the current national framework and guidance to support roles and responsibilities and how agencies and professionals should work together to promote the welfare of children. Section 2.27-2.96 clearly identifies the role of the Health Service.

1.2 Background and context to the study:

The role of Prime worker for Child Protection was introduced into the County in 1997, led by the Health Authority, supported by the Area Child Protection Committee (ACPC). It followed several case reviews that identified an urgent need to provide more effective support to General Practice (GP). This innovation was strengthened by research undertaken by Burton (1996:146) whose clear recommendations were "To identify a key child protection professional within the practice... to whom others will refer for information". In 1996, contact was made with the 123 GP Surgeries across the County suggesting GPs might nominate a named GP within the Practice. There was a negative response to this suggestion and six months later, GPs were asked to consider a named person in the Practice to undertake the role of Prime worker. The health visitor was thought to be the most appropriate person to undertake this role by the GPs. Objectives were set and disseminated and it was anticipated the Prime worker would develop and maintain effective communication systems within the Primary Health Care Team (PHCT).

Although this role was launched with some profile and local media coverage, locally it has never been formalised or evaluated. The ACPC procedures were based on the policy document 'Working Together' (DH 1999) and stated, "Each GP practice will have a named Prime worker for child protection" (Unreferenced for reasons of ACPC confidentiality). Commitment to the principles of this role is embedded within the Child Protection Operational policy of the PCT (Smith 2004). Each GP Practice has a nominated Prime
worker, therefore reaching the 100% requirement as stated within the document. However, there were no Standards by which to measure this role.

In 2004, anecdotal evidence from practitioners undertaking this role, raised concerns and it appeared there was confusion and developing uncertainty about the role. New members of staff assumed the title of Prime worker without induction or training. Analysis of the PCT Child Protection Operational Policy was undertaken in 2004 highlighting a gap in knowledge and understanding of the role and value of the Prime worker. Key recommendations proposed a review of the current system and a baseline audit that would provide standards that could be measured (Smith 2004).

Three audits were undertaken by the author and provide baseline data for this study. One audit looked at the role of Prime worker as perceived by those undertaking the role. Alongside that audit, questionnaires were sent to 80 members of the primary health care team (PHCT) to gain a perspective of the role and value of the Prime worker. A further audit was undertaken through a Commission for Health Improvement audit document, exploring the systems in place within clinical teams to protect and safeguard the welfare of children. The findings of these audits (see appendix) provided evidence at practitioner and primary health care team level, that there appears a general commitment to the role and value of the Prime worker and it should be continued and developed (Smith 2005).

The findings from the PHCT illuminate it is the knowledge, support and communication of the Prime worker that are most valued and effective. However, the results of these audits do not explain why the role seems to have lost momentum and were completely disbanded in the other four PCTs in the County. The results strengthen the need to answer the questions arising from the Policy Analysis (Smith 2004) and raised new ones questioning the organisational commitment to maintaining this role. How far is the
organisation 'signed up' to this innovation? What value does the Prime worker for child protection have to the organisation?

Co-operation and co-ordination in child protection is vital, in fact it is legislated through the Children Act (1989 & 2004). However, Lupton & Khan (1998:3) raise concerns that one particular characteristic of the child protection system may militate against effective co-ordination, and that is the sheer number of agencies and professional groups involved in safeguarding the welfare of children. Research abounds relating to the problems of multi-agency collaboration and communication and the author acknowledges that agencies must give this a priority. However, there are limited studies that have focused on one organisation and the issues and problems relating to effective 'internal collaboration' and working together. The few studies that have been undertaken also mainly focus on the practitioner, usually GPs, rather than the strategic or organisational level. The focus for this study stems from recommendations made from the policy analysis and service development work undertaken by the author (Smith 2004, 2005), particularly recommendation 5.6:

An in depth study to gain insight at a strategic level into the 'ownership' of the Prime worker role through ranking existing perceptions of the value of this initiative and how it is perceived staff should be supported in primary care in relation to child protection.

An organisational perspective is most relevant to the issues identified from the audits undertaken within the PCT. It will question if initiatives are not supported and valued by the organisation, how can they be maintained? Evidence at the 'grass-roots' level of the organisation, identified that the system in place for supporting staff of all levels 'on the ground' is valued and should be continued and developed (Smith 2005). The outcomes of the Policy Analysis and audits have strengthened the anecdotal evidence of developing uncertainty around the role and leads the author to question why a local initiative designed to strengthen communication within primary care in
relation to safeguarding children appears to have lost momentum. This will be the focus of this intra-organisational study.

1.3 Aims of this study:

1. To gain an organisational perspective to the role and value of the Prime Worker for Child Protection within Primary Care.
2. To explore the factors perceived as being important within the organisation in relation to safeguarding children.
3. To provide a comparison of the systems in place that support staff within primary care in relation to child protection.
4. To identify the best model for the PCT in relation to child protection support networks in primary care.

The key outcome of undertaking this research is the PCT will have a system in place that promotes and supports effective communication within primary care in relation to child protection.
2.1 Introduction to chapter

The intention of this chapter is to provide a detailed review of the topic being studied. It includes the context for development of the Prime worker role, the historical and current drivers to legislation and policy relating to child protection. In addition it explores key and current research. The aim is also to identify gaps in knowledge that could be addressed through undertaking this study and to inform direction of the design and data collection instruments.

2.2 How the literature was explored.

In planning a search of the literature around child protection, it became evident the topic under review was complex and limitations would need to be applied in order to contain and make sense of the evidence relevant to this study. Wider aspects relating to the topic were explored in order to ‘set the scene’ for the focus of this organisational research. Literature was reviewed throughout the research process; however it was important to consider the impact of adding new literature on the data collection method chosen for the study. Literature published after December 2006 has been incorporated into the Discussion chapter.

Initial exploration of child protection literature, revealed the term ‘Prime worker’ was a local term used to describe the initiative of supporting staff within GP practices and not a term specifically used outside the county. Alternative broader search terms were used (i.e. child protection, primary care, child abuse and neglect), and a detailed logbook records searches and terms used including Boolean operators and mesh searching in order to obtain a record of current and past research. Electronic alerts were set up to inform the author of new research and literature being published and these are recorded in the logbook. Evidence databases such as Cochrane and Campbell were extensively searched but did not yield any relevant research studies.
General bibliographic databases for example the British Nursing Index (BNI) and Cinahl generated useful results. Search of specific databases yielded a wealth of literature and were extensively searched using a variety of search terms until the results became repetitive and overlapping. Abstracts were screened with relevance to the research question. The databases of key professional organisations relevant to the topic were searched and are clearly recorded in the logbook. Searches for official publications were made through the Department of Health (DH) and Department for Education and Skills (DfES) websites and weekly alerts set up to notify of new publications. Personal contact was made with a number of key researchers and copies of specific research obtained. Copies of literature required were obtained through the library research support unit of the PCT.

2.3 Themes to be explored.

There is no single research paper published up to 2005 that adequately addresses the issues associated with supporting staff in primary care in relation to child protection. Gray (2004) attributes that research undertaken in an organisational context often stems not only from issues prompted by a body of literature but also from a real, live problem. The initial focus is the problem itself and literature is sought from both academic and grey literature.

From wide reading, a number of themes were evident, all of which have implications for child protection. The literature being explored has been divided into six themes:

- The development of the role of Prime worker – what is already known?
- Historical Perspective on the development of Child Protection Policy.
- The role of Health Professionals in the Child Protection Process.
- Child Protection and the Organisation.
- Leadership and Innovation.
2.4 The development of the role of Prime worker – what is already known?

The concept of the role of the Prime worker as it exists today within the PCT, is thought to have originated from research undertaken by Burton in 1996. This qualitative study looked at key issues for GPs in fulfilling their role in collaboration with other agencies responsible for child protection. An action research approach was viewed as the most appropriate methodology that would engage participants in the process of learning through critical reflection of their own practice of child protection and their attitudes towards collaboration with other professionals. This was an appropriate methodology as the focus was on a specific problem and the aim of the research was to empower the respondents to 'research themselves and their situation' and on this basis take responsibility for their own situation, make recommendations, possibly implement those recommendations and evaluate them. Data were collected from three multi-agency focus groups and interviews with GPs (n=6). GPs were also given case studies and other prescribed reading. Limitations to this study are that the entire focus and findings were on the GPs' role and perceptions and not of the primary health care team. The sample of only 6 GPs was small, although it was acknowledged difficulty with finding participants willing to participate. GPs were self-selected because they had an interest in child protection, therefore did not represent a cross-section of the GPs in that ACPC area, hence results could be biased and less generalisable to the area being studied.

Other studies have also highlighted problems in respect of GPs involvement in the child protection process, for example Bannon et al (2001, 2003a), Carter & Bannon (2002), Lupton et al (1999) and add validity to the findings of Burton's small study. Minimal literature was explored in the above study and data analysis was not clearly described. However, the findings and recommendations are valuable to the development of the role of Prime worker for child protection in primary care. Findings reported GPs felt they
were on the periphery of the child protection system and uncertain what was expected of them. Yet, this peripheral role existed within a context of high workloads and increasing demands for patient care. Within this context, GPs were expected to contribute to a process for which they perceived themselves as having little time, experience or appropriate training.

Recommendations focused on improving communication at the interface of general practice and social services. Recommendations were made relating to interprofessional collaboration as outlined below.

- To identify a key child protection professional within the practice e.g. GP, health visitor, practice nurse, practice manager, to whom others will refer for information. This person may need financial, educational, protected time and support as appropriate.
- To look at effective intra practice systems to ensure child protection information is not lost.
- To consider how information can be passed to case conferences and case reviews which balances the need for input from the primary healthcare team within the workload and time constraints under which GPs and health visitor's work. (Burton 1996:46)

Figure 2.1. Recommendations from Burton’s study relating to interprofessional collaboration.

From exploring this study it would appear many of these points have been taken forward with the development of the Prime worker role in the PCT being studied, but it is here too that a reason may have been found why the role has not been fully developed and momentum not maintained. It questions the importance of the statement 'this person may need financial, educational, protected time and support as appropriate'. Clearly from the results of the audit undertaken (Smith 2005), this had not been addressed at an organisational level.

Finding literature particular to the role of the Prime worker was extremely limited due to the fact this was a local innovation. Grey literature is often the foundation for organisational studies and a search identified a local study
undertaken by Fraher (2001). This unpublished BA (Hons) dissertation looked at the 'Role of the Prime worker for Child Protection' in one locality in the county. The aim of the study was to discover if prime workers undertaking the role thought the role should continue and to identify any perceived difficulties and benefits of the service.

Fraher (2001) makes continuous reference to another local evaluation undertaken in 1998, and several extracts from this evaluation are included in the appendix of her study, however they were not referenced. Extensive searching, trying to locate this unreferenced evaluation has proven fruitless; therefore the value of this grey literature to this study is unfortunately negligible. Following several re-organisations and staff changes, only one member of the original Prime worker ACPC sub-group could be located and remembered such an evaluation as being ‘inconclusive’. Recommendations made were not taken forward, including writing a protocol for the role of Prime worker. It could be questioned from the lack of dissemination of results and non-implementation of the recommendations of this study that by 1998, the role was losing momentum already despite 72% of the 64 people surveyed in Fraher’s study stating the role was important.

Fraher (2001) used questionnaires and interviews to compare what was happening in two localities in the county. Although there are limitations to this study, the findings are useful to compare to the audits undertaken by Smith (2005) and give strength to the proposal of undertaking an in-depth research study with the potential to become evidence other than ‘grey literature’ in this area where minimal research has been undertaken. Fraher (2001) concluded that the role of Prime worker should continue and it could make a valuable contribution to the child protection process in general practice. Protected time and training in order to undertake the role was highlighted as well as the need for a protocol and higher profile to the role. Recommendations stated that the role should be ‘renewed and relaunched’, and reinforced the proposal for the development of a protocol based on the original objectives and
training. This study, although providing some interesting background, has many limitations that question its reliability and validity. The rationale for choice of methodology was not well described and the method of analysing data not discussed. Ethical considerations of the study were not clear and research questions poorly described. None of the recommendations from this 2001 study have been taken forward by the locality in which this study was undertaken.

2.5 Historical perspectives and the development of Child Care Policy.

Current policy on child protection does not represent a new beginning; it has been fundamentally influenced by what has gone before. Therefore, the historical context is important in that the protection of children has required a national policy response that is interpreted and applied at a local level. Fox Harding (1991) summarises historical drivers of childcare policy (that still apply today) in that factors influencing law, policy and practice can be divided into four broad areas:

1. Scandals, inquiries and the response.
2. Interest groups and their thinking.
3. Reviews of legislation and policy.
4. Wider policies and changes.

Child protection policy originates back to the pre-modern 1600s (Tindall and Alaszewski 1998). Although the NSPCC was formed in the late 1890s, there was a reluctance to intervene in family life as children were viewed as being 'owned' by their parents. For the purpose and length of this study, the period prior to 1960s although fascinating reading will not be explored here.

In the 1960s, emotive terms such as 'battered baby' were used. This focused heavily on physical signs of abuse and historically highlighted society's growing sensitivity to the occurrence of child cruelty. The death of Maria
Colwell in 1974 caused a public and media outcry that led to significant development in child protection policy and practice. The inquiry into Maria's death was followed in the 1980s by other high profile child death inquiries that severely criticised roles and responsibilities of professionals involved with the children and their families. This decade was an important milestone forming the foundation for multi-disciplinary collaboration of policy today, although the legislative 'duty to cooperate' did not come until the 1989 Children Act.

Hallett and Stevenson (1980), Parton (1985), Watton (1993) and reinforced by Parton (2004) argue repeatedly that child protection failures resulted from poor communication and collaboration. Yet, despite over thirty years of policy development, these are still top of inquiry report recommendations (Laming 2003). In the 1980s, research was published identifying characteristics and risk factors for abuse, particularly the work of Browne and Saqi (1988). The significance of this for policy makers in the late 1980s were several other high profile inquiries i.e. Cleveland (1988) that began to question professional knowledge and procedures amongst professionals as well as in the media. Professionals were faced with trying to manage the fine balance of intervening to protect the child with protecting the child and family from (unwarranted) interventions. The impact on policy was a shift to assessment and management of risk as central within child protection.

'Messages from Research' (DH 1995), was funded by the Department of Health following the high profile inquiries in the 1980s. It summarises and disseminates the results of twenty childcare research projects commissioned following the identification of a gap in knowledge, and to the responses made following identification of child protection concerns. These studies provided major insights into the operation, decision-making and outcomes of child protection systems and processes and posed many questions in the late 1990s for policy makers and practitioners leading to debates about the future direction of child protection.
Parton et al (1997) explore further some of this research, particularly how children and families were filtered through the child protection process and they describe studies nationally and internationally highlighting the significance of this to the late 1990s re-think and re-evaluation of child protection policy and practice within the UK. Parton et al (Ibid) reinforce the need to develop ideals, future policy and practice in the 21st century would be informed by detailed empirical research with a shift to looking at children in context of what is happening, rather than focussing on isolated incidents. By the late 1990s this led to a referral criteria and threshold shift to ‘children in need of support’ rather than only on ‘children at risk’ and this began developing the formative ideas of a holistic ecological approach to the care of children – a more balanced approach between preventative and tertiary interventions. The Working Together to Safeguard Children policy guidance (DH 1999) and Assessment Framework (DH 2000a) were compiled as a response to recognised deficiencies in the system and incorporated research findings into a multi-agency guidance and best practice ideology. These documents provide strategic guidance from which operational instructions and policy at a local level are formulated, as well as guidance as to how agencies should work together. They strengthened the shifting focus from ‘improving communication’ to ‘working together’. The need for a consistent approach across agencies has been further reinforced by development of the Common Assessment Framework (CAF) that is gradually being implemented from 2005.

2.6 Policies informing Practice in the 21st Century.

Since 2001 there have been significant legislation and policy changes that continue to impact on the provision of health care services for children. The review of the case of Lauren Wright (NSPCC 2001) made a fundamental criticism of both health and social services over reliance on others to take responsibility for the protection of children. Likewise, following the death of Ainlee Walker in 2002 there were striking similarities noted to past and recent inquiries that show common threads that led in each case to a failure to
intervene early enough, poor coordination, a failure to share information and
the absence of a strong sense of accountability. Lord Laming published his
report in 2003 following the inquiry into the death of Victoria Climbie. These
reports and the Bristol Inquiry (Kennedy 2001) have significantly impacted on
policy and legislative changes of the early 21st Century:

Outstanding findings of the Laming Inquiry were:

- Failure of basic good practice. There were 108 recommendations with over half
  relating to 'good basic practice and needing immediate action'. 27 recommendations
  relate to the health service and 4 relating specifically to GP practice. This has
  particular interest to this study as they relate to systems in place to support staff in
  their role in safeguarding children and reinforce that child protection is a part of
  safeguarding children that cannot be separated out from family support.
- Training: in particular, ill trained and overworked staff that were poorly supported.
- Accountability: in particular, senior management who failed to take responsibility.  
  (Laming 2003)

Figure 2.2 Outstanding findings of the Laming Report (2003).

In response to the Laming Report (2003), the Government published a Green
Paper 'Every Child Matters' which proposed changes in policy and legislation
to focus local services more effectively around needs of children and families
(Department for Education and Skills 2003a). The Children Act 2004 gives
legislative effect to the proposals outlined in this document and includes a
duty placed on all health organisations to ensure they have systems in place
that safeguard and promote the welfare of children. The Act strengthens
requirements of local partnerships to deliver improved outcomes for all
children and young people. These national five outcomes are:

- Stay Safe
- Be Healthy
- Enjoy and Achieve
- Make a Positive Contribution
- Achieve Economic Well Being (DfES 2003a)

It is perceived by the author that 'on the ground level' within primary care,
the role of Prime worker rates highly in being able to fulfill this. Therefore, in
this study the perception of the role will be important as viewed by wider stakeholders than just within the PCT being studied.

Every Child Matters: Change for Children in Health (DH 2004a), set out the health agenda for children to how the five outcomes set for all children will be achieved and improved. It details support the Government will provide for the implementation of the National Service Framework for Children, Young People and Maternity Services (NSF). The NSF for Children (DH 2004b) sets out a 10-year programme to stimulate long-term and sustained improvement in children’s health and well-being. The NSF forms part of the NHS ‘Developmental Standard’ — standards that NHS Organisations must work towards and are taken into account in the Healthcare Commission work. Safeguarding children is a key theme running through the NSF and Every Child Matters Policy agenda. Standard 5 relates specifically to the ‘Staying Safe’ outcome for children. It also reflects priorities identified in paragraph 11 ‘Keeping Children Safe’ (DfES 2003b). Choosing Health, the Public Health White Paper (DH 2004c), identifies the health of children as a priority so people start on the right path to health and provides parents with the support they asked for in giving their children a healthy start.

The Chief Nursing Officer’s Review (DH 2004d:6) highlighted a number of fundamental issues needing to be addressed in relation to protecting vulnerable children and young people:

- Better skills in identifying and supporting vulnerable children and families across the workforce and confidence in taking steps to safeguard children at risk.
- Better child health promotion and protection in general practice.
- Care is often fragmented between health, social care and education, between the hospital and the community and between nurses, midwives and health visitors.
- More effective leadership and governance is needed in such areas as child protection.
- More intensive preventative healthcare for vulnerable families in antenatal and early postnatal period. (DH 2004d:6)

Figure 2.3 Key fundamental issues to be addressed from Chief Nursing Officer’s Review (DH 2004d).
These issues could be effectively taken forward and addressed through developing and promoting the role of the Prime worker for child protection within primary care.

An analysis of the PCT Operational Policy was undertaken in 2004 as an assignment relating to this course of study (Smith 2004). The Operational Policy states the underpinning philosophy and commitment of the PCT in respect to the protection of children. It is the scope of the policy that has shifted since the introduction of the 'Working Together to Safeguard Children' document was implemented in 1999 (DH) and Laming (2003:43) reinforced this. Previously, child protection within 'Health' was deemed the responsibility of those whose work brought them into direct contact with children and their families. This shift has broadened to include all staff, thus widening responsibility and has significantly impacted on the service from the researcher's perspective both strategically and at the delivery level. The implications and requirements of this on the provision of training and supervision support for all staff, rather than just those who work directly with children and families are not to be underestimated. Therefore, it would appear that the innovation of the role of Prime worker would be more crucial now than in 1997.

Jacqui Smith MP clearly defined the child protection responsibilities in her letter to PCTs dated 28th January 2002 (DH). This was a response to Shifting the Balance of Power within the NHS: Securing Delivery (DH 2001), part of the Government's 10 year Modernisation Plan which stems from the NHS Plan (DH 2000b). It enumerates that as power is being shifted down the line, it is essential that a proper focus on child protection is maintained.

2.7 The role of Health Professionals in the Child Protection Process.

This section looks at the role of health professionals in the child protection process and child protection in the context of primary care. In this context
Primary Health Care Team (PHCT) refers to the services provided for children in primary care by the GP, practice nurse, health visitor and administrative staff.

2.7.1 The Children Act 2004.

The Children Act 2004 is the legislative basis for the 'Every Child Matters Change for Children Programme' and the reform of Children's Services. It builds on and strengthens the framework set out in the Children Act 1989 and incorporates the wider agenda for safeguarding and promoting the welfare of children. The Children Act 2004 required the local authority to set up a Local Safeguarding Children Board (LSCB) in April 2006 to replace the Area Child Protection Committee. The LSCB now has more accountability and is required to monitor member agencies efforts to safeguard and promote the welfare of children. Section 11 of the Children Act 2004 places duties on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote welfare. Chapter 5 identifies key requirements for the Health Service (HM Government 2005).

In 2006 as the study was in progress, 'Working Together to Safeguard Children' (HM Government 2006) replaced the 1989 'Working Together' document. These documents clearly identify roles and responsibilities for health professionals in safeguarding children. There was a need to review this guidance to support legislative changes and the 'Every Child Matters' policy agenda. 'Health professionals and health organisations have a key role to play in safeguarding and promoting the welfare of children' (Ibid:11). Roles and responsibilities are clearly outlined in Section 2.27-2.96.

2.7.2 The role of Health Professionals in the Child Protection process.

Carter and Bannon (2003) emphasise the importance of health professional's role in safeguarding children, in that they are often the first to be aware a family is experiencing difficulties in looking after their children.
There is limited published research specific to child protection in Primary Care. A large study undertaken by Lupton et al (1999) funded through the NHS Executive provides some interesting insights into the 'Role of Health Professionals in Child Protection'. The framework for the study was inter-agency collaboration and the background to undertaking this work was literature and studies that generally focused on the aetiology of child abuse rather than on how it is managed by the agencies concerned. The study was undertaken in 1995-1996 and sought to describe the roles played by a range of different health professionals and to identify from the perspectives of all central participants, factors which appear to facilitate or inhibit their effective participation in the inter-agency and inter-professional process.

A research strategy of case study was applied, this approach being particularly useful when trying to uncover a relationship between a phenomenon and the context in which it is occurring. An inductive process was taken to the research and a multiple method approach to collecting data in order to achieve triangulation. The findings of this large study will be discussed relating only to the relevancy to the proposed research. Strategic views were obtained and less than half the senior managers interviewed in the core agencies perceived there was effective collaboration between health and non-health professionals at the operational level. The majority described information exchange rather than 'hands on joint working'. Of all health professionals, hospital based clinicians and GPs were generally perceived by strategic level staff to be the groups least clear about their role in child protection compared to other professional groups, as well as being seen to be the more difficult groups for other professionals to work with. These findings are supported in the studies undertaken by Bannon et al (2003a) and Burton (1996).

Frontline views also support the findings of Burton (1996), that GPs were perceived by the majority as least extensively engaged in the child protection process. Dominant views of frontline staff identified they were most unclear
about their role and that of others. Health visitors were viewed to have a high
degree of involvement and interest and most commonly perceived by others
as ‘essential’ in child protection work. Health visitors self rated highly their
contribution to the detection and management of child protection cases and
were seen to play a key role in the detection and management of child
protection by strategic staff in health and social care agencies.

Lupton et al (1999) highlight some of the challenges for GPs. GPs reported
they were fairly clear about their role in the child protection process. The
difficulties were seen to derive from the demands and expectations of others,
notably social services to meet this role in a particular way. The majority of
GPs felt that they had little time for, or experience of, child protection which
was generally seen to comprise a small part of the GP workload. The GP saw
on average two child protection cases per year.

GPs considered the health visitor’s role in child protection was more
significant than their own. Most reported they relied on health visitors to
provide information on the social situation of the child in order to assess risks
and often devolved to these staff the responsibility for decision-making about
referrals. GPs were perceived to have the most significant medical role as
they have regular contact with children and families. However, there was
widespread dissatisfaction by other disciplines over their role.

The impact of ongoing structural and organisational changes in the NHS was
seen as particularly problematic in fracturing the health service. Lupton et al’s
study (1999) highlights the debilitating effects that the almost continuous
process of externally driven organizational change in the public sector had on
inter-agency working, with numerous changes in structure and culture of the
health services placing new demands on health professionals and targets.
This study provided evidence such cumulative pressures adversely affected
the capacity of certain health professionals (e.g. GPs) to take a more
participatory role in child protection. The impact of constant organisational
change on child protection was not fully explored within the study but has identified a gap in knowledge and will be explored further in this study.

Key recommendations from Lupton et al's (1999) study were:

1. Identification of a child protection professional within the practice e.g. GP, health visitor, practice nurse, practice manager to whom others can refer for information with appropriate training, support and protected time.

2. Examinations of intra-practice systems to ensure adequate mechanisms are in place to signal the possibility of child abuse.

It seems from the large number of recommendations that the role of Prime worker could go a long way to meeting some of these recommendations and ultimately improve communication, networking and liaison. Many recommendations were also proposed by Burton (1996). This is the only published research that could be located giving some focus to the strategic view of child protection although this study does not focus on primary care alone. Lupton et al (2001), take these recommendations further in later published work:

... a more sensible approach might be to designate the health visitor as the primary health care team's representative and key worker in the child protection process ... this would clarify responsibilities and legitimise the role that, de facto, many health visitors assume (p.150).

Lupton et al (2001:15) explore Benson's (1983) model of 'interorganisational policy analysis' as a framework for the analysis of the internal dynamics of the multi agency and interprofessional networks operating in child protection. Benson's four dimensions of equilibrium are described and applied in relation to how Benson's framework can assist in understanding the impact of external factors on the internal dynamics of a network.
1. Domain consensus – Agreement regarding the appropriate role and scope of each agency.
2. Ideological consensus – Agreement regarding the nature of the tasks faced and the most appropriate way of approaching them.
3. Positive evaluation – By workers, in one organisation of the work of others.
4. Work coordination – Alignment of working patterns and cultures.

(Lupton et al 2001:15)

Figure 2.4. Benson’s (1983) four dimensions of equilibrium.

Benson’s framework has also been used by the author in the work leading to this study (Smith 2004, 2005) and remains an interesting theoretical perspective to carry forward and apply in the discussion of the findings from this study as it allows focus on the phenomenon being studied as well as the wider safeguarding context.

2.7.3 Child Protection in the context of Primary Care.

A large group of vulnerable people are children. Where children have supportive, caring parents or guardians, children have a natural advocate and protector. Where such support is missing, the PHCT becomes a key element in that child’s care (Pringle 2002: Foreward).

Working Together to Safeguard Children (DH 1999) states the vital contribution of the PHCT (section 3.28-3.33) in safeguarding and protecting children, particularly their unique and continuing contact with children and families. This is reinforced in Working Together (HM Government 2006) in section 2.74-2.83, specifically relevant to this study it states ‘There should be good communication ... in respect of all children about whom there are concerns’ (Section 2.79).

Evidence from research carried out during the last 30 years has placed child abuse and neglect within the most serious health conditions affecting children and Carter and Bannon (2003) emphasise it should be looked at like any other life threatening illness.
Carter and Bannon’s Position Paper for the Royal College of General Practitioners (2002) on the ‘Role of Primary Care in the Protection of Children from Abuse and Neglect’ highlights the key roles that GPs, health visitors, practice nurses and other members of the PHCT play in the protection of children. The findings reflect Lupton et al’s (1999) research and focus heavily on the role of GPs and the problems and barriers to GPs engaging in the child protection process rather than on the needs of the PHCT. They reiterate Burton’s findings (1996:9) in that numerous changes in structure and culture have continued over the last fifteen years to bring new demands on GPs. Jones and Gupta (2003), Narducci (2003) and the Royal College of GPs Strategy for Child Protection (Bastable 2005a) reinforce these difficulties.

These findings strengthen the recommendations of Burton (1996) and Lupton et al (1999) of the need to ‘identify a professional within the practice who will be responsible for managing and updating members of the PHCT ... a named lead for child protection ... plan regular meetings to discuss children at risk and their families’ (Carter & Bannon 2002:12). Bannon et al (2003b:49,58) identify a ‘paucity of research around child protection and primary care’ and propose that ‘this might represent a priority for future research’. Again, like Lupton et al’s (1999) study, emphasis is placed on considering what financial and educational support as well as protected time is required in order to undertake this role. A recommendation from this study advocates that ACPCs should consider appointing a GP liaison person who is ‘responsible for ensuring flows of information from GP Practices...’ (p18).

The Department of Health (2004e:3) published guidance on the National Service Framework for Children, Young People and Maternity Services – Key Issues for Primary Care. It highlights that the vast majority of contacts with the health service for children are within the primary health care team. In a typical year, pre-school children will see their GP about six times whilst school age children 2 or 3 times. Most consultations ... can be effectively dealt with by the GP, practice nurse or health visitor’. It is vital therefore that staff
working in primary care are aware of their responsibilities for safeguarding children and that a supportive network is established at the 'grass-roots' level where issues and concerns can be identified at the earliest opportunity in a proactive and preventative way.

The Department of Health (DH 2003a) published guidelines for the appointment of GPs with 'Special Interests in the Delivery of Clinical Services: Child Protection. This General Practitioner with Special Interest (GPwSI) framework is one of a number that the Department of Health commissioned the Royal College of General Practitioners (RCGP) to produce. The concept emerged following the Working for Patients' White Paper (DH 1989) and was taken forward in the NHS Plan (DH 2000b) and Shifting the Balance of Power (DH 2001). They are intended to be advisory, offering best practice for the development of local services. In the PCT where this study was undertaken, the initiative has not been taken forward, however the author is aware it has in neighbouring counties. Initial questions are raised as to whether this role would replace the Prime worker role established? Analysis of the document would indicate it is not the primary health care team that is the focus of this initiative – but GPs. It would appear the role is more of a strategic role akin to that of Named Dr and Named Nurse for the PCT. It is not clear how many of these GPwSI a PCT should have and in considering a GPwSI, there are significant financial implications for the PCT. Within the study it was important to explore what other PCTs are doing in order to establish systems and communication networks to safeguard children within primary care. Honey and Small (2005) explore GPwSI and the potential benefits and possibilities for primary care. Unfortunately, child protection was not identified as a role for GPwSI.

Poblete (2003) stresses the importance of regular PHCT meetings to plan care, share concerns and put in place preventative measures to address issues and provide early support to vulnerable children and families. Also, to coordinate health care for those children already identified as at risk of harm.
Goveas’s article in ‘Children Now’ (Goveas 2005a) is enlightening into discussion of ‘The joined-up GP’. The article reports on interviews with a GP in Lincolnshire who established a local multi-agency child protection team within the primary health care team setting. He describes the system in place where vulnerable and at-risk children are reviewed by a multi-agency team meeting each month chaired by the GP. The success of this innovation is discussed and the positive impact it has on communication, sharing information and multi-agency working. It was interesting to note his comments:

> Because we're meeting regularly and sharing information face-to-face there is a much stronger element of trust ... trust is key to the whole process ... GPs can view social workers as prying ... and social workers can view GPs as obstructive and uninterested (Goveas 2005a:20).

The report highlights some of the difficulties for GPs in engaging with child protection, not least the impact of the GMS Contract on facilitating multi-agency training. The report also proposed the vehicle which the Government has chosen for encouraging GPs to work more closely with children’s services was the NSF for Children, Young People and Maternity Services. The GP being interviewed commented that he believed:

> What was needed was for trusts to commission child protection as a service GPs can opt into, so they are given the time and money to prioritise it

Another GP interviewed gave importance to the role of the health visitor who would take the lead on children’s issues. He stated there were benefits of having health visitors allocated to his practice as well as benefits from formal and informal meetings and discussions around children and their families. There were many interesting issues discussed in this article of relevance to this study and the author viewed many of these as being important to follow up as the study developed.

Another high profile Serious Case Review (Sheffield ACPC 2005) identified and severely criticised the health visiting and GP services for lack of proactive steps to promote the children’s welfare. Over a two year period, poor internal
communication systems and sharing of information led to an accumulation of information that should have been recognised as a cause for concern in a potentially vulnerable family and should have prompted further action. Recommendations from this Review could apply to any ACPC (now Local Safeguarding Children Board) and reinforce research evidence and recommendations made by Burton (1996) and Lupton et al (1999), in particular:

*The PCT should develop in consultation with general practices, recommended systems and processes for inter-professional liaison (about children) and seek to secure implementation of such arrangements by all practices (Recommendation 21).*

2.8 Child Protection and The Organisation.

This section will explore organisations and the management of change, accountability and emotional intelligence and safeguarding children.

2.8.1 Organisations and the management of change.

Glennie (2003:176) highlights *"changing policy is one thing; changing behaviours of individuals within a complex system to conform to policy intention is another"*. The pace of change in the health services including primary care has been unrelenting. A highly skilled workforce is needed to meet the increasing demands from the public and politicians. Constant change since the Labour Party came into power in 1997 brings in to question how organisations manage change, not only changes within child protection, but also organisational change within the NHS particularly related to primary care. Changes within the NHS are seen as part of a process, never likely to be straightforward and linear but the far-reaching changes that are occurring cannot occur in a vacuum. Hart and Fletcher's (1999) work on organisational change found change is most likely to be achieved in an environment which positively supports changing and suggests change does not necessarily
require an increase in material, physical resources, but inevitably entails recognition of the beneficial potential of human resources. Hart and Fletcher (Ibid) reiterate any change in response to policy in by theory and research, and this is the key intention of the researcher in undertaking this study.

The timeline in the appendix highlights the amount of organisational, legislative, national and local policy change in the period from 2004 – 2007 in which this study was undertaken. During a time of significant structural change, it is crucial that safeguarding children and child protection is considered to be a priority by the PCT and each member of staff. The findings from national and local reviews into child deaths reiterate that the reorganisation of services and organisations can in itself create pockets of weakness, particularly in systems designed to support and protect children. This reinforces the importance of staff feeling confident and well supported in their work with children and families, and that communication throughout the period of change must be prioritised.

Theories proposed by Huy (1999) provide a valuable framework in order to ascertain how the PCT as an organisation is managing change. Applying the literature explored suggests the PCT has acknowledged the importance of ‘emotional capability’ as an organisation and given consideration to ‘emotional Intelligence’, which will confront the drivers and resisters to change (Ibid). It has actively sought to engage all levels of staff in the change processes through providing formal and informal communicational structures that facilitate ‘ownership’ and forums for the ‘emotional release’ and displacement of feelings regarding the change being imposed / suggested. This relationship of organisational and individual support can be equally applied within child protection where at a meso level i.e. The LSCB (previously ACPC), Locality Child Protection Groups and other local multi-disciplinary networks are forming ‘emotionally supportive’ structures as a forum to debate and ‘come to terms’ with the reality of the constant policy changes. It can also act as a
bridge for change behaviour between micro and macro levels (Ibid). It could be argued that only those who are willing to consider change engage in seeking and attending informational and emotional support networks and the true resisters to change may remain cynical, demonstrate withdrawal behaviour and possibly prepare to sabotage change (Audit Commission 2004).

Undertaking the policy analysis (Smith 2004) left many questions unanswered. While it is clear that only a very small proportion of children subject to child protection interventions ever experience the types of harm and injury which typify the cases which have captured the imagination of the media and have been subject to public inquiries, there is no doubt it is the ‘heavy end’ cases that have driven policies and procedures and influenced day to day practice and decision-making. Since 1997, the Labour Government appear driven to bring about change yet such prolific changes within the NHS, and particularly within primary care, has allowed very little time to settle down and truly reflect, stabilise and consolidate. Certainly there has not been time to become complacent about what is working well. Child protection policies will never be permanently fixed as national and local policy is driven by the legislative requirements of ‘the best interests of the child’. This means there is constant review of policy and procedures in light of new evidence. It is this shift to research underpinning practice that has brought agencies working closer over the last fifteen years and been applied to formulate multi-agency practice tools and procedures.

As the 2004 Children Act is being implemented, it is within a constant period of change and future uncertainty for the precise direction of future policy that will impact on the welfare of children and the collaboration of those working in a child welfare environment. Already changes have been implemented the bringing together children’s services under one Governmental department – Department for Education and Skills, appointing a Minister for Children and implementation of Children’s Trusts. In primary care changes are just as prolific. PCTs were formed in 2002, yet already restructured by 2006 with
planned devolution of commissioning to GP Practices (DH 2006a). The White Paper 'Our Health, Our Care, Our Say (DH 2006b) envisaged Practice Based Commissioning as one of the solutions to delivering effective prevention and innovative locally based healthcare as well as giving patients more choice in primary care.

2.8.2 Analysis of the PCT Child Protection Operational Policy.

The focus for this study stems from recommendations made from an analysis of a PCT Child Protection Operational Policy and Service Development Project undertaken in 2004/5 as part of the Doctoral programme. The concept of Prime worker is firmly embedded in the child protection policy of the PCT being studied.

One of the theoretical perspectives used as a framework in the above studies was Benson (1983) and this is taken forward in this study as a 'common thread'. In analysing the findings of the two audits undertaken for the Service Development Project, Benson's (Ibid) model of Interorganisational Policy Analysis was applied at the intraorganisational level, as it was noted there was still the potential for conflict over the key dimensions for equilibrium. These dimensions have been previously explored in this chapter in relation to Lupton et al's 2001 study (Section 2.7.2).

The ethos of developing the role of Prime worker was to improve inter and intra organisational working. Within an organisation there are many different disciplines, external and internal drivers for the attention of the workforce and resources available to sustain initiatives. It could be argued with the initiative of the Prime worker role, there was now a widening gap in the domain consensus (who does what) and ideological (how it is done) consensus. Evidence of a 'positive evaluation' of the role was identified in the audits and provides the motivation to continue to explore this topic. There is evidence of 'alignment of working patterns and cultures', but at this stage not across all
PHCTs. It was viewed as crucial by the author that the intra organisational perspective of the role of Prime worker is obtained if the four key dimensions of equilibrium described by Benson are to be fully implemented, formalised and the initiative re-launched and sustained. It was also recognised there were limitations to this ideology, as organisations such as the PCT are 'highly susceptible to external pressures and are cross-sectoral and multilevel in nature' (Lupton et al 2001:23).

2.8.3 Accountability.

Accountability is at the forefront of the constant changes within child protection and Working Together (HM Government 2006) reiterates the development of shared responsibilities in safeguarding children. Increasingly the government stresses the need for multiple sources of accountability (Checkland et al 2004, Lewis 2004). Criticism towards the NHS was justified from The Laming Report (2003:5), which concluded 'the principle failure to protect was the result of widespread organisational malaise' and recommended a clear line of accountability from top to bottom. This statement gives strength to undertaking this research.

The PCT is accountable for the systems in place to safeguard and promote the welfare of children in what can be described as upwards, downwards and horizontal levels (Hunt 1994). Downwards, it is accountable to the population served and in this aspect – the best interests of the child must be paramount (Children Act 1989). Chief Executives are responsible for ensuring that the obligations of the health service in relation to child protection are fulfilled (Smith 2002). The Healthcare Commission through Core Standard 2 of the Health and Social Care Standards and the planning framework monitors this for 2005-2008 (Healthcare Commission 2004). Section 11 of the Children Act 2004 requires senior management commitment to the importance of safeguarding and promoting children's welfare, and to demonstrating leadership and accountability as outlined below.
A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.

Service development that takes into account of the need to safeguard and promote welfare.

Effective information sharing.

Effective interagency working to safeguard and promote the welfare of children.

Safe recruitment procedures. (Section 11 Children Act 2004).

Figure 2.5 Senior management commitment to Section 11 Children Act 2004.

The PCT Board and Professional Executive Committee (PEC) provide the formal structures of accountability within and outside the PCT. This includes the requirements that all those with whom the PCT commission services have systems in place to safeguard and promote the welfare of children (including GP Practices). Upwards they are accountable to the Strategic Health Authority (SHA) who monitors whether structures are in place to support and implement the policy directives both nationally and locally. This includes the identification of lead professionals (Named Doctor and Named Nurse) to take forward child protection responsibilities. The SHA’s role is performance managing and supporting the development of NHS and PCTs arrangements. This is achieved through quarterly progress monitoring in relation to the National Service Framework for Children, Young People and Maternity Service.

Focus on quality drives and delivers the modernisation agenda of the Labour government and has seen the devolving of and increasing accountability given to PCTs. In one direction, the PCT is accountable to the Local Safeguarding Children Board (LSCB) as they are signatories to the multi-agency child protection procedures document. The LSCB is required to monitor and evaluate the effectiveness of what is done by Board partners to safeguard and promote the welfare of children and advise them on ways to improve (HM Government 2006:80). In the other direction, the PCT is accountable to the workforce. This includes the entire workforce, clinical and non clinical irrespective of their role with children. This requires structures to be in place to support and supervise staff in their role in the protection of children and
ensure that a tiered approach to training needs are developed and implemented (HM Government 2006). The present PCT policies and protocols address this (including the protocol for the role of Prime worker). In relation to Section 11 requirements of the Children Act 2004, the PCT has put a system in place through the role of Prime worker, working to ensure that those from whom they commission services safeguard and promote the welfare of children. Therefore, the PCT has an investment in its success and future development.

Within the PCT, individual practitioners are also accountable, dependent on their role and responsibilities as laid out in their job description. Practitioners are front line executers of policy and their clinical decisions have important resource and management consequences:

*Those in senior positions in organisations carry on behalf of society, responsibilities for the quality, efficiency and effectiveness of local service... a yawning gap... the fault of managers because it was their job to understand what was happening at their front door* (Laming 2003:5).

Professional accountability is a central pillar in the construction and maintenance of an autonomous profession; therefore professionals are accountable to their professional organisation i.e. Nursing & Midwifery Council, General Medical Council, through a system of specific professional codes and a system of professional accountability. Professionals are also accountable to their peers dependent on their role, to ensure safe and best practice is observed and disseminated.

2.8.4 GPs responsibility and Child Protection.

GPs’ responsibilities to child protection are clearly outlined in the British Medical Association document published in 2004 and reinforced within ‘Working Together’ (HM Government 2006) and local County Child Protection and Safeguarding Procedures.
The Quality Outcomes Framework (QOF) is a component of the General Medical Services Contract (GMS) for general practices, introduced in April 2004. The QOF rewards practices for the provision of quality care, and measures achievement against a scorecard of 146 indicators within four domains. There are minimal requirements within the QOF relating specifically to children and only one requirement for child protection – procedures to be available to staff (ref: CHSI).

In 2005, the Royal College of General Practitioners (RCGP) published 'Keep Me Safe', a five-year Strategy for Child Protection which aimed to enable GPs to respond more fully and effectively to child protection issues. Goveas (2005b) identifies how through the strategy, the RCGP requested child protection to be included in the practice's clinical governance arrangements when the GMS Contract was reviewed. The strategy explores the GPs' role in child protection and reiterates some of the difficulties GPs have in recognising and responding to child abuse, and also explores the 'opportunities for early intervention' (p.4-7). The strategy identified plans to develop a qualification for GPs that would equip them to act as leads within primary care trusts or over a number of practices and highlights the earlier work of Carter and Bannon (2002) in emphasising the role of GP should go beyond recognition and reporting to include interprofessional collaboration and education and to identifying a key professional in each practice to lead on child protection issues. The strategy outlines how this could be achieved, including supporting the development of GPs who wish to become PCT and / or practice leads in child protection. To date, this strategy has not been taken forward in the PCT being studied but is viewed by the researcher as an area of importance to be explored further.

2.9 Leadership and Innovation.

This section will look at leadership and innovation in child protection. Thompson and Mchugh (2002:253) enunciate that innovation is:
Regarded as increasingly important, primarily because it is taken to be a key indicator of how successful organisations are in adapting to more rapidly changing and complex environments.

This work will be explored further in respect of the outcomes of poor implementation, factors that help or hinder, and the climate and culture required to sustain innovations such as the Prime worker role.

If Prime workers are to become the 'champion' within primary care in respect of child protection as outlined in PCT policy, then urgent consideration must be given to exploring why this role has been allowed 'to drift' and lose momentum. Does the problem stem from lack of 'ownership' or understanding? Is it the consequence of constant change? Is it a role supported at strategic (Strategic Health Authority, PCT Board) as well as practitioner level? How far will the PCT support the development of this role and should it be re-launched to raise profile and strengthen policy? What do other counties do? A role traditionally designed for GPs but does it need to be?

Sarah Mullaly (DH 2004d) reinforces and strengthens the role nurses, midwives and health visitors have in working with vulnerable children and families and makes recommendations for the future role for nursing in her response to the publication of 'Every Child Matters' in 2003. Many of these recommendations could be taken forward within Primary Care through the role of the Prime worker. In developing the role it is in line with the ethos of modernising and developing primary care including time to 'liberate the talents' (John Reid, DH 2003b).

There is no room for complacency in child protection. There is always a need to be vigilant to the need to change and enhance the systems in place to protect children. Clearly there needs to be strong leadership and commitment to child protection within primary care whilst also acknowledging the time restraints and 'multiple roles' of practitioners. Knowledge and understanding
of child welfare and policy has evolved and developed over time, informed by research, experience and critical scrutiny of practice. PCTs must recognise that their goals whether delivered through policy or reports can only be successfully achieved by engaging fully with clinicians ‘at the front line’.

Shifting the Balance of Power (DH 2001) brought about new forms of nursing leadership and a change in the culture of management and leadership from Department of Health to the front line. Clinical leadership courses now extend to lower grades of staff as the leadership skills of the entire qualified workforce are strengthened through local and national programmes, facilitated and strengthened through the Kings Fund (Kings Fund 2004) and NHS Leadership Programme. ‘Shifting the Balance of Power and devolving responsibility’, yet there are potential dangers. Child protection requires tight, coordinated and strong leadership. How can roles be developed yet not become a fragmented child protection service? Encouragement to pursue this stems from the speech given by John Reid encouraging and promoting ‘inspiration and entrepreneurialism’ at the Chief Nursing Officers Conference November 2003 and to the winners of the Health & Social Care Awards July 2003 (DH 2003b, DH 2003c).

Lownsborough and O’Leory (2005:33) reinforce leadership as the critical lever and ‘the nexus around which a context can be created in which cultural change is a valued goal for everyone’. The challenge for leaders is not just to alter one professional culture but also align many sets of professional values. Parton (1994) warns of the child protection process becoming over ‘proceduralised’ leaving little room for professional discretion or innovation. Morrison (2006) stresses the importance of local leadership as a major lever in bringing about change and emphasizes it cannot be achieved from the centre; organisations need to develop a culture in which change can happen. He also acknowledges that for success, innovation must have ownership. Hart and Fletcher (1999:54) add a note of caution here in that although ownership is vital, it must be allowed to evolve over time via shared values and
2.9.1 Emotional Intelligence and Safeguarding Children.

Organizations that are emotionally capable are more likely to achieve change (Huy 1999:2).

Child protection is an emotive area in which to work and the literature cannot be ignored as it has direct influence on what creates and sustains a system in its current form. Morrison (2006) questions how we help those where safeguarding is not their core business, hold on to their child protection responsibilities and sees emotional intelligence as having a key role. He argues that although emotional intelligence cannot carry all the politics, it has great importance particularly when the underlying individual versus organisation drivers can be quite destructive when trying to be innovative. He identifies what is needed is an inner awareness and confidence to be sufficiently attached to the 'political master', but also detached in order to meet service needs. To achieve this, often requires the need to mediate between the politics of power and the politics of emotion, and it is vital to build emotional intelligence into all aspects of change management and multi-agency working.

There is a strong link in this study to the adapted Kolb reflective cycle (Morrison 2006) that gives credence to incorporating the emotional intelligence approach: experiencing the story, reflecting, trying to understand the phenomenon being studied and a plan of action. In respect of how the Prime worker innovation has been sustained in one PCT, there would appear to have been a strong link to it being an emotionally literate organisation. In

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1 Emotional Intelligence facilitates individual adaptation and change and emotional capability increases the likelihood for organisations to realise radical change. At the organisational level, emotional capability refers to an organisation's ability to acknowledge, recognise, monitor, discriminate and attend to its member's emotions, and it is manifested in the organisational norms and routines related to feeling. These routines reflect organisational behaviours that either express or evoke certain specific emotional states (Huy 1999:325)
the existing network, relationships are built on the 'spirit of mutuality', collaboration, and where feelings are understood and anxieties processed. Respondents help to shape effective decisions, enrich discussions and formulate ideas in a supportive environment which Morrison (Ibid) views as crucial.

2.10 Conclusions from the literature.

The literature underpinning this study has been explored in relation to six key themes. As a result of the literature review, certain gaps in knowledge and questions were identified as particularly important to the research design:

- There is limited research focusing on child protection and primary care.
- A gap exists in research that examines how recommendations from published research have been taken forward and implemented.
- A gap in organisational and strategic perspectives exploring the child protection needs of the primary health care team.
- The impact of constant organisational change on child protection networks and systems has not been explored.
- How important is organisational 'ownership' to maintaining innovations?
- A comparison of innovations and initiatives relating to child protection supportive networks. Is a universal model appropriate?
- Is the PCT meeting the requirements of current legislation and national policy in respect of safeguarding children within primary care?
2.11 Research questions:

The principle research question of this study is:

'How should staff be supported in primary care in relation to safeguarding children?'

The main areas to be examined are:

- From an organisational perspective, is there a role for a Prime worker for child protection within primary care?
- The role of Prime worker for child protection - whose interests does it serve?
- From an organisational perspective, who is perceived the most appropriate person to undertake the role of Prime worker for child protection within primary care?
- What value does the 'organisation' place on maintaining this role?
- How is the organisation prepared to support and develop this role?
- What is the best model and how can it be taken forward in the PCT?
- What does the organisation perceive as the impact of constant change and reorganisation on child protection within primary care?
- What is the order if any, of the apparent disorderly phenomenon relating to the role of the Prime worker?
Chapter 3

3.1 Introduction to chapter

This chapter will discuss theoretical and philosophical perspectives underpinning the research, the design of the enquiry and justification for the particular choice of method. An overview of the Q-methodological approach will be presented, with an explanation of how the concourse and final statements were selected and prepared for the Q-sort. Discussion in relation to expert validation and participant selection will be presented. Ethical issues considered during the study will be explored and a justification for how data were prepared and analysed will be presented.

3.2 Theoretical perspectives and the philosophical underpinning of the research.

Crotty (2003) suggests an interrelationship exists between the theoretical stance adopted by the researcher and the methodology and methods used. An inductive approach has been adopted in this study. This paradigm of enquiry does not set out to corroborate or falsify a theory; it attempts to establish patterns, consistencies and meanings (Gray 2004:6). In order to clarify a research design, various epistemological perspectives were explored. Of particular relevance to this study is constructivism: 'truth and meaning do not exist in some external world, but are created by the subject’s interaction with the world' (Ibid: 17).

The focus for this study stems from recommendations made from an analysis of the PCT Child Protection Operational Policy and Service Development Project undertaken in 2004/5 as part of the Doctoral programme, particularly recommendation 5.6 (Smith 2005).
Recommendation 5.6

An in depth study to gain insight at a strategic level into the 'ownership' of the Prime worker role through ranking existing perceptions of the value of this initiative and how it is perceived staff should be supported in primary care, in relation to child protection.

The concept of Prime worker is firmly embedded in the child protection policy of the PCT being studied. This study aims to:

1. Gain an organisational perspective to the role and value of Prime worker for child protection within primary care.
2. To explore factors perceived as being important within the organisation in relation to safeguarding children.
3. To provide a comparison of the systems in place that support staff within primary care in relation to child protection.
4. To identify the best model for the PCT in relation to child protection support networks in primary care.

A logical extension of the theoretical paradigms already explored would be to follow a constructivist approach. This would have been the most obvious model to adopt in looking at the role of Prime worker from different standpoints. From this stance, subjects construct their own meaning in different ways, even in relation to the same phenomenon. This was considered important in order to answer the research questions of this study. There are a number of theoretical paradigms adopted in this thesis which have been used as analytical tools. Triangulation of theoretical paradigms is considered appropriate and the justification for this is outlined below.

A theoretical paradigm linked to Constructivism is Interpretivism (Gray 2004:16), this being a major anti-positivist stance. This study seeks to gain perspectives of an organisation to a particular phenomenon, that of the Prime worker for child protection. Perspective seeking approaches tend to be interpretative and generate qualitative data – 'perspectives being the mental view of the relative importance of things' (Pearsall and Trumble 1995:1084).
Interpretivists set out to understand individuals' interpretations of the world around them, therefore data yielded with the meanings and purposes of those people who are their source. The theory generated must make sense to those to whom it applies and this is important to this organisational study. The interpretative process is particularly useful when little is known about the phenomenon under review and the aim is to try and understand something in its context. Morse (1992) suggests interpretive study is characterised by three main features: The emic perspective, the holistic perspective and an inductive interactive approach of inquiry between the researcher and the data.

A theoretical perspective used as a framework in the work leading to this study was Benson’s (1983) model of Interorganisational Policy Analysis, and this theoretical perspective is taken forward as a common thread. In analysing the findings of the audits undertaken for the Service Development Project, Benson’s (1983) model of Interorganisational Policy Analysis was applied at the intraorganisational level, and it was noted there was still the potential for conflict over the key dimensions for equilibrium as proposed by Benson. This model has also been explored in the literature through the work of Lupton et al (2001). Exploring this framework facilitated the focus and development of the research questions for this study.

Undertaking the background work to this study, it was acknowledged the theoretical paradigms adopted in the Policy Analysis and Service Development project although important, did not quite capture the confusion and complexity surrounding the role of the Prime worker and a new theoretical perspective emerged which juxtapose other paradigms in exploring and answering the questions of this study – Chaos Theory as described by Wheatley (1999). This approach was appealing to the researcher and the decision to adopt triangulation of theoretical paradigms rather than a traditional Constructivist approach was made.
The theoretical constructs of Chaos originate in biology, mathematics and computer science, but Brocklehurst (2004) identified its popularity within change agents in primary care. He proposes that confusion, contradiction and complexity seem appropriate in virtually every sphere of professional activity from policy to practice. His argument relates to health visiting, although his concepts can also be applied to child protection systems and networks. The findings of the audits conducted in 2005 would not describe the system of Prime worker as truly chaotic, yet there is evidence of confusion and uncertainty and the system in place being sensitive to changes in conditions. It could be argued child protection and the systems in place to protect children can never become linear and organised. Behaviour tends to conform to a basic set of implicit rules directed by policy, although ‘events can and do produce unpredictability and novel patterns of organisation and relationships. When combined, they result in an apparent paradox of superficial chaos’ (Ibid: 135). Unfortunately, society has not seen the last child death inquiry nor have we been able to provide robust systems to protect all children from abuse or prevent human error. However, Morgan (1997:263) proposes ‘if a system has a sufficient degree of internal complexity... instability become resources for change...new order is a natural outcome’. Therefore, at this stage with the evidence provided from the audits, this would appear an appropriate and interesting theoretical perspective to explore in trying to understand the direction the Prime worker role has taken and may take in the future. This notion is supported by Hutchinson (2004:2) who proposes the growing interest in this theoretical concept to shaping a world increasingly characterised as ‘complex, interconnected and rapidly changing’ and Quinn Paton (2002:124), who proposes chaos theory challenges our need for order and prediction even as it offers new ways to fulfil those needs.

Child protection and safeguarding children is emotive and it can be difficult for practitioners from all agencies, often working in a media culture of blame where safeguarding systems are often portrayed as being chaotic. It is acknowledged that it is a difficult environment to work in where a balance
needs to be maintained between over-intrusiveness and professional neglect and incompetence.

Exploring this phenomenon through chaos theory should lead to creativity. Wheatley (1999:XV1) describes chaos as a necessary process for the creation of new order given 'a world where chaos and order exist as partners, where stability is never guaranteed or desired'. It was highlighted in the introduction to this study that Primary Care Organisations are in a period of constant organisational change. The Service Development project identified that what was needed was a wider perspective to the emerging question of 'how do we manage constant organisational change yet still have systems in place to safeguard children within primary care?' In this time of constant organisational change, Gleik (1987:24) offers a metaphor to explain the very nature of the inquiry into chaos:

*It's like walking through a maze whose walls re-arrange themselves with every step you take.*

Wheatley (1999:117) asserts that change and constant creativity are ways of sustaining order but in order to see how chaotic processes reveal the order inherent in a system, requires the shift of vision from parts to the whole.

*When we concentrate on individual moments or fragments, we may only see chaos, but if we stand back and look at what is taking shape, we see order.*

Order always displays itself as patterns developing over time, and this links here to the Inductive approach to the study – patterns emerging from stepping back and looking at the whole picture, not just the apparent confusion surrounding the Prime worker role and how and who should support staff in primary care in relation to safeguarding children.

From chaos comes new order, as Wheatley (1999) describes it; a new relationship with chaos is possible and things we fear most in organisations –
disruption, confusion and chaos need not be interpreted as a sign we are about to be destroyed (Prime worker innovation worthless). Instead, these conditions are necessary to reawaken creativity. The researcher's intention in undertaking this study is to emerge with information necessary to make change and develop stronger systems to safeguard children. It is acknowledged in the present situation, that to achieve new growth may require exploration through fearful realms of possible disintegration – initially reflected in some of the anecdotal evidence presented at the beginning of the Doctoral research programme.

3.3 The right method to explore the value of the Prime worker role.

The research questions sought to gather opinions and perspectives from participants on the role and value of the Prime worker for child protection within primary care. Therefore, it was important to select a robust technique for measuring subjective opinion. 'The central endeavour in the context of the interpretive paradigm is to understand the subjective world of the human experience' (Cohen et al 2000:22) In this study, the method chosen should be able to retain the integrity of the phenomenon being studied and to get inside the person and to understand from within (emic perspective). The method chosen should allow exploration and not make assumptions about what the results of the study may be. The principle research question of this study is:

How should staff be supported in primary care in relation to safeguarding children?

The main areas to be examined are outlined in Section 2.11 (page 37).

3.4 Design of the Enquiry

The rationale for the decision to apply a qualitative approach to the study is that it would provide insight into the participants' feelings, thoughts, attitudes and opinions obtained through participants' views and experience. It also
relates to the paradigm of enquiry in which 'inductive discovery' is being adopted (Gray 2004). The purpose of this study was to explore and try to understand what was happening in a specific context and gain a perspective of organisational attitude and commitment to the role and value of the Prime worker for child protection. The aim of the study is perspective seeking and methods used to gain perspectives tend to be interpretivist and generate qualitative data (Robson 2002).

3.5 Choosing the right Method.

At the outline stage of this study, consideration was given to various qualitative methological approaches appropriate to the interpretive paradigm and a variety of methods were critically reviewed.

Action research was considered as this would involve close collaboration between researcher and participants, and place an emphasis on promoting change within an organisation. Improvement and involvement are central to action research and Lewin (1946) first introduced action research as a way of learning about organisations through trying to change them. He also sought to gain information on attitudes and perspectives that were also important to this study. The intention was to explore the issues and improve the phenomena being studied but not necessarily to change it. Action research studies typically take longer to collect the data and staff changes during the study can be disruptive (Gray 2004). This was an important consideration for this study as by November 2006, only 4/10 participants in this study were still in post due to PCT reconfiguration and organisational changes!

Discourse analysis was considered but most often requires in-depth interviews or discussions (Robson 2002:365). Discourse analysis (sometimes called conversational analysis) refers to the study of how both spoken and written language is used in social contexts and attention is given to the structure and organisation of language with an emphasis on how participants' versions of
events are constructed (Robson 2002). Discourse was considered very important to this study; however consideration needed to be given to the high profile participants within the ‘organisation’ being studied and whether an interview would be an appropriate method. This might have resulted in a tabled response to what they think the researcher wants to hear. This was an important consideration in choosing the methodology as the researcher also had a high profile role within the organisation and would be administering the research tool selected.

Discussion with a research supervisor, questioned the appropriate use of either method. The author was initially unfamiliar with the methodological approach selected, but was directed to read some literature around Q-methodology. This proved to be interesting and inspiring. Choosing the ‘Q’ approach challenged the researcher who was used to a more straightforward qualitative approach and thematic or paradigmatic analysis.

3.5.1 Q-sort methodology

Q-methodology offers researchers a powerful tool for systematically examining subjective data. It is a research method with a proven history for illuminating agreement and differences among individual and group perceptions. This methodology therefore seemed appropriate to the topic and in answering the research questions of the study. Using the ‘Q’ approach would also add to the originality of the study as limited research has been published around the topic being studied (Shaw 2001, Stainton-Rogers and Stainton-Rogers 1992) and none found relating to child protection within primary care. Hutchinson (2004) values the Q-method and chaos theory link in that insights derived will benefit translation of complexity theory to the social sciences and he explores how Q-methodology potentially augments existing techniques for examining complexity.
Robson (2002) describes Q-methodology as a technique used to measure the relative position or ranking of an individual on a range of concepts. Stephenson first described this technique in 1936 and drew on the letter 'Q' to represent the methodology and conceptual framework associated with the study of subjectivity and in recent years it has become a popular tool for researchers in social sciences. Brown (1991) proposes although due largely to its mathematical substructure 'Q' is fairly well known in quantitative research, but he draws attention to qualitative Q-methodology gaining credibility among qualitative researchers. Examples of this can be seen in the work of Mercer (2006), Stenner et al (2007). Q-methodology 'combines the strengths of both qualitative and quantitative research traditions' (Dennis and Goldberg 1996:104), and provides a bridge between the two paradigms of inquiry. This study has a strong qualitative focus as discourse during and following the Q-sort is deemed valuable to the researcher, as it will illuminate the reasons why participants believe. Q-methodology has no interest in estimating population statistics, but rather the aim is to sample the range and diversity of views expressed, not to make claims about the percentage of people expressing them. It is concerned with hearing 'many voices' and what makes it unique is how those voices are allowed expression (Stainton Rogers 1995). Stainton Rogers (Ibid:250) also argues Q-methodology is a quintessentially alternative methodology for those dealing with discourse and text and it may provide a grid 'in which to make their story'. Indeed, Goldstein (2006) advocates Q-sorting because it encourages a person to move to a higher level of awareness than by undertaking interviews. Mercer (2006) used this qualitative approach to Q-methodology to gain perceptions of the political, professional and policy drivers leading to the Implementation of the Care Standards Act 2000.

Stephenson proposed all experience is demonstrated through behaviour and this method allows for subjective 'expert opinion' to be presented in an interesting and non-judgemental way (McKeown and Thomas 1988). Q-sort methodology can be employed to assess, in a highly structured and systematic way, people's understandings of an issue from "their own particular viewpoint..."
it is about capturing the way in which meaning is organised and patterned” (Ibid:5). Brown (1996:561) proposes that this technique is valuable to those interested in the subjectivity involved in any situation including the perception of organisational roles.

A Q-methodological approach was selected as it was more informal and allowed the researcher to be viewed as a neutral analyst by the participants rather than a senior colleague working in the County being studied. The Q-technique enables the participant to display a particular viewpoint on an issue of subjective importance without being unduly constrained by the viewpoint of the researcher. A method focusing on interviews could have been more likely to produce a regurgitation of policy from the senior staff being asked to participate in the study. This method would also allow participants to consider a whole range of views and 'hear many voices'. Lovemore (1989) and Mercer (2006) advocate a Q-sort as a technique for exploring self and that it is enjoyable and fun for participants.

The Prime worker is integral to the PCT Child Protection Policy. Undertaking this methodological approach will provide evidence of where the PCT is at, in respect to achieving Benson’s (1983) dimensions of equilibrium for effective Policy implementation as outlined by Smith (2004) in the analysis of the PCT Policy. Hutchinson (2004:2) states ‘in the field of policy, Q-methodology has been usefully applied for the purposes of problem-solving, particularly problems deemed complex’ and therefore would appear an appropriate link with chaos theory. Using this methodology was considered suitable to the inductive approach to this study as McKeown & Thomas (1988:29) describe 'inductive designs emerge from the patterns that are observed as the statements are collected'. The aim of Q-methodology is not to obtain the truth, but to collect and explore the variety of accounts people construct.

Cross (2005a,b) endorses Q-methodology and argues how it is a more robust technique for the measurement of attitudes and subjective opinion than any
alternative method and actively promotes its use within the field of health. Cross (Ibid) explores how attitudes may influence behaviour that in turn may directly affect outcomes. Also, attitudes are often concealed and not directly observable in themselves but cause actions and behaviours that are observable, and having a view implies evaluation and is concerned with how people feel about an issue. Two common measurements of attitudes and opinions are the Likert Scale and Semantic Differential, but Cordingley et al (1997) and Zraik and Boone (1991) argue Q-methodology is more focused than a general attitude questionnaire.

The instrumental basis of Q-methodology is the Q-sort technique which conventionally involves the rank ordering of a set of statements from agree to disagree. Participants are presented could also be used). Brown (1996) describes this method where individuals are invited to rank the set of statements along a scale anchored by say +5 (most happy with) through to −5 (least happy with). This usually consists of between 60-100 cards (the Q-set) and the activity of ranking them is generally known as Q-sorting (Polit & Hungler 1999). It is unwise to use fewer than 50 items because it is difficult to achieve stable and reliable results with a smaller number. More than 100 cards, the task may become tedious and difficult (Polit & Hungler 1999:394, McKeown et al 1999:254). In using Q-method, the variables are the people performing the Q-sorts, not the Q-sample statements. Brown (1980:39) proposes that Q-samples provide a 'launch pad for an investigation – an entrée into a phenomenon'. Q-methodological approach allows 'many voices to be heard' through the generation of the statements, the Q-sort and through discourse generated whilst undertaking the sort. The term discourse has been used throughout the study to denote the comments freely made by the participants during the sort process. The word discourse has been selected as it was not a conversation (Robson 2002:365).
3.6 Issues of Rigour.

Some of the issues relating to validity and reliability of the research have been and will be discussed throughout the study; other issues will be discussed here.

3.61 Validity and Reliability.

Validity and reliability are important to the 'trustworthiness' of a study and are of particular importance where there is reliance on data that is generated from a particular sample or situations (Gray 2004). Consideration has been given to internal and external validity. It was important the research questions were answered and the design, methods and data analysis selected were appropriate and justified. Robson (2002:171) describes some of the threats to validity in flexible designs (Description, Interpretation and Theory) and these have been considered i.e. tape recording interviews and providing verbatim transcriptions, an 'audit trail' by charting, recording and justifying how decisions and interpretations were made including peer debriefing. Research and diary logs were also maintained throughout the research study to provide transparency of the decision-making processes. Peer examination of the data was undertaken throughout by a focus group, expert validators, from research academic advisors and from within the organisation being studied.

Triangulation is a valuable strategy to enhance the rigour of qualitative research (Robson 2002). Data, methodological and theoretical triangulation were used in this study to strengthen the reliability of the research process.

References to how the threats to validity described by Lincoln and Guba (1985) can be reduced were also considered (reactivity, participant biases and researcher biases) and the importance of the researcher remaining open to the findings. A reflexive stance has been adopted with constant consideration of possible researcher influence on the study. Consideration was given to whose frame of reference were they 'telling their story from' – theirs or mine? Whilst collecting the data, the researcher tried to acknowledge and prevent any non-
verbal cues and response i.e. did not cut across what participants were saying or prompt and remained aware at all times of the potential for researcher bias.

Maxwell (1996) proposes that in flexible designs, internal generalisability has importance. External generalisability is less important as this is a study of a particular 'case' and findings will only be generalisable within the county where the study will be undertaken. However, this study builds on the literature and recommendations from published studies and it is anticipated the findings will have value to a wider audience outside the PCT being studied. Of particular importance to a Doctoral thesis, the findings should have analytic or theoretical generalization (Gray 2004, Sim 1998, Yin 1994).

In selecting a free-sort technique, the uncomplicated distributional requirements and the smaller number of categories allowed a larger number of stimuli to be used, thus increasing the instrument's reliability and validity. The justification for selecting a free-sort technique will be discussed. However, it has other advantages in that an unforced Q-sort requires less time to complete than a forced sort. This was an important consideration to the people requested to participate in the study and the limited time available. Bolland (1985) proposes that the use of a free-sort potentially increases the content validity of the Q-sort instrument, and since the Q-sort instrument is less complicated than the forced sort, the response rate may be higher and more stimulus statements can be used. In this study, 100% response to sorting the statement cards was achieved.

To ensure content validity, the final number of statements was selected and categorised by a focus group. A substantive pilot was undertaken with guidance throughout the study from a colleague with expertise in the qualitative approach to Q-methodology.

Several statements in the sort were similar and placed across categories to test and draw out strongly held views. Participants during the sort were prompted
to review the siting of their statements and to make changes if they wished. This aspect of recognition and flexibility aimed to generate a sense of control over participants’ contributions and of the reliability of the Q-sort process.

3.62 Trustworthiness

Gray (2004:345) argues that in a naturalistic tradition, trustworthiness of research is more important than concerns over validity and reliability and due consideration has been given to transferability, dependability, conformability and credibility issues. Also viewed as important was a consideration of authenticity and in relating ‘analysis and interpretation to the meanings and experiences that are perceived by the subjects of the research’. The research acknowledges the multiple voices contained within the data, and the sometimes-conflicting realities within it. Q-methodology is reputed for ‘hearing many voices’ and therefore most appropriate to this study.

To summarise this section, the Q-method technique was selected as the most appropriate method to:

- Uncover different patterns of thought.
- Identify important internal and external constituencies.
- Defining participant viewpoints and perceptions.
- Identifying criteria that are important to clusters of individuals.
- Examine areas of friction, consensus and conflict.
- Capture and explore the confusion, contradictions and complexity of the Prime worker role.
- Constructivism & Chaos Theory is encompassed in this methodological approach.
3.7 Methods

3.7.1 The Concourse.

The Q-method enables participants to express their viewpoints via the medium of sorting a particular set of items, usually statements written on cards. In Q-methodology the discourse about a specific topic is referred to as a 'concourse', and it is from this concourse that a sample of statements is drawn (Brown 1991). The effective 'Q' study depends upon meticulous and thoughtful sampling of the propositions and a concourse can be sought in a number of ways. Naturalistic Q-samples are compiled by obtaining written or oral statements around the topic being explored, whereas ready-made samples are compiled from other sources i.e. journal articles, literature.

In this study items from naturalistic and ready-made were combined to form a hybrid Q-sample (McKeown 1988) of literature (e.g. Bannon et al 2001, Fraher 2001, Lupton and Khan 1998), journal articles (Health Service Journal, Children Now), two audits (Smith 2005) and a focus group. The aim was to seek to ensure the fullest range of viewpoints in the Q-sort deck. 141 statements were generated (see appendix 6).

Stainton Rogers et al (1995:249) reinforce the importance of the final statements selected, as 'people can only tell a story if they have the appropriate statements with which to tell it'. In this study, it was important the statements also reflected the perceived chaos and confusion around the Prime worker role. Hutchinson (2004:2) elucidates how the concourse is 'the echo of the complexity being studied'.

3.7.2 Selecting Q-set representative of the range of communicated ideas in the concourse.

A 'modified' focus group of existing Prime workers were asked to look at and prepare the final cards for the Q-sort. The focus group technique involves the
simultaneous use of multiple participants to generate data and aims to get closer to participants understandings and perceptions of certain issues (Morgan 1998). The aim of involving existing Prime workers was to maintain engagement of practitioners in the study and to keep it practitioner focused. Asking the Prime workers to select the final statements would also help reduce bias; compared to where the researcher had selected them herself.

Letters were given to members of the Prime worker group at a staff meeting inviting them to return a tear-off slip if they were willing and able to attend the focus group. The letter outlined the study and what the group would be asked to do. Permission was obtained from their manager to approach staff.

Six Prime workers responded to the letter. Unfortunately, due to last minute work commitments, only four were able to attend on the day. The group was reminded of the study focus and the research questions – these were visible throughout on a flip chart. The researcher explained she was presenting them with 141 cards. Each card had a statement on it. The researcher explained the statements were subjective and drawn from the literature, audits and personal communication. The group was asked to select the final number of statements to be used in the Q-sort (between 60-90), considering statements to include widest viewpoints. They were given three pots in order to ease selection and asked to put cards in the ‘relevant, not relevant and unsure’ pots. They were also given blank cards in case the selection process generated other statements deemed appropriate for the study. Whilst selecting the statements, they were asked to look at how the cards could be clustered and this formed the basis for the subdivision into categories.

The group was also asked to comment on the size and font of the words on the cards. They were given two sets to compare – Verdana size 12 and Tahoma size 12. The group selected Verdana as being clearer to read. They also changed the wording on three statements to aid clarity.
The focus group commented how interesting the process had been. The selection of statements generated debate and lively discussion. The group could only narrow the final selection to 98 statements and included excluding statements they viewed as unclear. They generated four new statements and some of the comments made are interesting to note:

*If you don’t understand it, they won’t ... If the words are not powerful ... Needs to be good wording as the people are used to focusing quickly.*

3.7.3 Structuring the Q-sample

The focus group was given a blank flip chart and asked to write down any categories generated in the preparation of the cards. They selected four.

1. Communication  
2. Roles  
3. Responsibilities  
4. Working Together

This confirmed the researcher’s perspective they were the most appropriate selection of categories as they closely matched the selection she had chosen but not shared with the group (collaboration, roles & responsibilities, communication, accountability and impact of change).

Following the focus group, the researcher arranged the statements into the four categories selected. Presenting the statements in categories would facilitate the sorting of smaller piles, rather than participants being faced with one large pile to sort. The researcher reviewed all the selected statements and excluded those that were repetitive. The final number of statements for the Sort was 85 (statement 21 and 46 were removed just prior to the pilot as they were deemed repetitive but this had not been noticed until after all the cards had been prepared and numbered). The final statements were reviewed again to verify the Q-set was representative of the wide range of existing opinions about the topic in the concourse. Several similar statements were placed across categories deliberately in order to compare and contrast where they were
sorted. The statements comprising the final Q-set are listed in the appendix and sourced as to their origin.

3.7.4 Identifying the topic categories for the sort.

It was important to identify categories in order to facilitate the sort process for the participants, rather than being faced with 85 cards to sort at one time. However, inductive designs emerge from the patterns that are observed as the statements are collected and the categories selected will not have been obvious prior to statement collection (McKeown & Thomas 1988). Brown (1980) stresses how the selection of statements from the concourse for the inclusion in the Q-set is of crucial importance.

3.7.5 Expert validation.

Guidance was sought in the preparation, focus group, piloting and analysis stage of the research process from a supervisor with extensive experience in the qualitative approach to Q-methodology. Her background was health visiting, and, therefore she also had significant insight into child protection. Screening of the initial statements led to revision where for example two statements were presented as one and therefore were ambiguous or confusing. It also drew attention to repetitive statements and those where clarity was needed. Guidance was also sought on the sort process, including appropriate coloured card, style of writing to use on statement cards, preparation of the participation information sheet etc, building on her experience of the expert.

3.7.6 The 'Sort' process.

Q-sorting requires the participant to sort the statements along a continuum of 'most agree' to 'most disagree', generally in the presence of the researcher. Consideration was given to whether a 'free-sort' or a 'fixed-sort' would be more appropriate to this study:
1. A free-sort where the sorter places the cards wherever they wish.  
2. A forced-sort where the sorter must balance the sort so that fewer cards are placed on the extremities with the majority of the cards being focused towards the centre of the continuum. This selection method enables the sorter to prioritise their most important issues. This selection process ensures the researcher can identify each selector's most important issues and provides an alternative process to rank ordering and allows factor analysis to be applied to the data.

<table>
<thead>
<tr>
<th>Least important</th>
<th>No opinion</th>
<th>Most important</th>
</tr>
</thead>
<tbody>
<tr>
<td>-5 -4 -3 -2 -1</td>
<td>+1 +2 +3 +4 +5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>number of cards.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 5 4 3 2 1</td>
</tr>
</tbody>
</table>

Figure 3.1. Example of a 'forced' distribution of Q-sort cards (Polit and Hungler 1999:395) showing a hypothetical distribution of 60 cards.

According to Polit and Hungler (1999), the forced procedure of distributing cards to a fixed-sort is the subject of criticism. Critics argue this artificial procedure tends to exclude information concerning how people would ordinarily distribute their opinions and participants' frustration is lowered in a free-sort because they are free to place Q-sort cards at any place under the distribution markers (Cordingley et al 1997, Denzine 1998, Gaito 1962, McKeown et al 1999, Polit & Hungler 1999 and Rohrbaugh 1997a). Block (1961) argues the forced-choice approach loses certain 'information' that would be retained if unforced distribution of judgements were considered. Bolland (1985:93) also criticises the over-emphasis on fixed sorting and points out it may potentially mask important inter-participant differences and he advocates a free-sort as being more reliable as participants are not required to 'sort stimuli using what may be an artificially complex system'.

A free-sort was selected as it appeared more compatible with the qualitative and perspective seeking focus of the study and could generate more discourse allowing elaboration on the participant's beliefs through narratives that should
complement and triangulate with the data from the Q-sort. Participants are in no way restricted when given a free-sort condition of instruction. They are free to place as many of the cards under the distribution markers as they desire. The decision to apply a free-sort was affirmed by contacting and discussing the method with Professor Rohrbaugh at University of Arizona. He made reference to conference papers and research undertaken (Rohrbaugh 1997a, b) and also with reference to the work of Mercer (2006).

<table>
<thead>
<tr>
<th>Most Disagree</th>
<th>2</th>
<th>14</th>
<th>22</th>
<th>1</th>
<th>16</th>
<th>9</th>
<th>5</th>
<th>12</th>
<th>8</th>
<th>4</th>
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<tr>
<td>-5</td>
<td>19</td>
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Figure 3.2. An example of how 24 Q-sort cards could be spread using a free-sort condition of instruction.

A record sheet was devised to record the data from the individual sorts.

3.7.7 Pilot

A pilot was undertaken with the aim of testing the research tool. This was viewed as an important part of the study as the researcher had not undertaken a Q-sort before and wanted to gain confidence and competence in this approach. In addition, a pilot would ensure statements were checked with participants for balance, comprehension and clarity of expression and comprehensiveness. The Q-set was piloted with a small convenience sample and minor alterations were made. Pilot participants were selected to include expertise in Q-technique, child protection, to have representation from a senior member of staff in the PCT being studied and a PCT Director who may not have extensive child protection knowledge.
3.7.8 Pilot Participants

1. **Named Nurse for Child Protection (P1).**
She had extensive knowledge of child protection and who had been a Named Nurse for over 3 years. She worked in a neighbouring PCT in the county. She was familiar with the Prime worker role and never participated in a Q-sort.

2. **Health Visitor & School Nurse Manager (P2).**
She had been in post for six months. Her background was school nursing and education. She was selected as a senior member of staff in the PCT being studied. She had never participated in a Q-sort.

3. **Q-sort expert (P3).**
She was included in the pilot as she had extensive experience of using Q-methodology. Her experience included a qualitative approach and the use of free Sorts. Her background was health visiting; therefore she also had a sound knowledge of child protection issues. She worked as an academic in a University and remained a key validator and advisor throughout the study.

4. **Non-Executive Director (P4).**
He was included as a PCT Director who may not have extensive knowledge of child protection. He had participated in several Q-Sorts. His role also involved undertaking Quality Outcome Assessments in primary care.

The pilot was undertaken at the workplace of the participants, with one being undertaken at the participant’s home. Following the pilot, a box was prepared that contained all the equipment required to undertake the Q-sorts.

3.7.9 Modifications following pilot.

Following the pilot, no changes were made to the final Q-set. However, consideration and modification was given to:
1. The need to collect basic demographic data on sort participants (P1).
2. Modification to the consent form to delete ‘medical care’ (P1)
3. The need to remind participants a large table was required in order to complete the sort. P2 provided a small round table in a small room, and the researcher felt ‘on top of’ the participant, which seemed intimidating.
4. Minor changes to some wording on the ‘condition of instruction’ sheet, particularly a stronger emphasis to participants that there was ‘no right or wrong way to sort the statements’ and it was ‘your personal opinion’ that was required. P3 advised this needed to be re-iterated throughout the sort.
5. Placing the title of the study at the top of the distribution markers on the table in front of the participant. Almost immediately, P3 found it difficult to remember the focus of the study. The researcher improvised immediately by writing the title on a piece of paper and placing it where it could be easily referred to.
6. Taping the Q-sort. P3 made comments throughout the sort, discussing where each card was placed, justifying and comparing. The researcher became overwhelmed trying to capture and write down the valuable data. It was decided to ask the participants if they would allow the sort to be audiotaped in order to capture all comments made.
7. Using post-it notes to facilitate collecting up of the statements from each set of statements (P3).
8. The importance of the researcher not getting into a discussion with the participants. The pilot was valuable in reinforcing this as the participants asked questions or wanted to discuss with the researcher. The participants were therefore reminded at the beginning of the sort process that the researcher could answer questions about the sort, but could not engage in conversation or discussions about the statements.
9. The need to ensure, rather than presume that participants would understand the terms used i.e. PHCT (P4). For those participants not familiar with primary care or PCTs, the two abbreviations used in the statements were identified under the title of the study.
3.7.10 Setting and Sample.

As the Prime worker role was an initiative of a sub group of the Area Child Protection Committee, it was important to gain perspectives from a wider sample than just the PCT. For the purpose of this study, the setting is a PCT in the UK and the 'organisation' or 'case being studied' included members of the ACPC (now Local Safeguarding Children Board), Children Trust, Strategic Health Authority as well as PCT. The major concerns of Q-methodology is not how many people believe, but with why and how they believe what they do (McKeown and Thomas 1988). Q-methodology aims to reveal and explicate some of the main viewpoints that are favoured by a particular group and large numbers of participants are not required. Indeed Brown (1991), Watts & Stenner (2005) warn such an approach could be problematic. This approach is also aligned to qualitative studies generally working in-depth with small numbers.

The sample for the Q-sort was identified using purposive sampling to gain a sample of 10 key influential personnel within the organisation who had key strategic roles and influence on child protection within the County and ultimately the PCT as stakeholders. Purposive sampling is deliberately non-random and aims to sample a group with particular characteristics. A non-probability sampling approach is appropriate to this organisational study where generalisability to the population is not important. However, it is anticipated the findings provide evidence that other PCTs would take forward and develop their own strategic direction on supporting staff within primary care in relation to child protection. The participants were selected to gain a balance of those working in the PCT being studied with those working in safeguarding children. Two participants worked both in the PCT being studied and safeguarding children.

Participants were approached via letter outlining the study (see appendix), and were invited to participate. Of twelve people contacted, two did not initially respond. They were not contacted again in the belief they may not wish to
participate in the study. Several months later, the researcher was contacted by both people who profusely apologised for not contacting her (due to illness or pressure of work). Both expressed an interest to participate in the study, however by then the data collection had been completed.

3.7.11 Participants in the study

This descriptive information about the participants is intended only to indicate diversity of the group and to supplement findings with some context. None of the participants had participated in a Q-sort before.

1. *The lead PCT Director for Child Protection in the County (R1)*
   She had worked since 2002 as lead Director for Child Protection in the County being studied. She did not work within the PCT being studied but represented the PCTs on the Area Child Protection Committee. Her background was health visiting.

2. *Integrated Service Manager (Social Care) (R2)*
   He had been in his present post for 18 months. His background was social work. His post involved co-ordinating multi-agency working in relation to vulnerable children.

3. *Assistant County Child Protection Advisor (R3)*
   She had extensive experience as a social worker and had been an Assistant County Child Protection Advisor for 18 months. Her role involved co-ordinating child protection and multi-agency working across the County. Previously she had worked in the Child Protection Unit as a Locality Child Protection Advisor Chairing Conferences.

4. *General Practitioner / PCT Clinical Lead for Clinical Governance (R4)*
   He was a General Practitioner and had been Clinical lead for Clinical Governance for eight years in the Primary Care Group / Trust being studied.
5. **Chief Executive (R5)**
She was the Chief Executive in the PCT being studied and had been in post since 2002. Prior to 2002, she was Chief Executive in a local Primary Care Group.

6. **Director of Community and Intermediate Care (R6)**
Since 2002, she has been the lead Director for Child Protection in the PCT being studied. She was a member of the PCT Safeguarding Children Group.

7. **Strategic Health Authority (R7)**
She was the Strategic Health Authority lead for Child Protection and had been in post for over three years.

8. **Director of Public Health (R8)**
She had been the Director for Public Health in the PCT being studied since 2002.

9. **Non-Executive Director (Children) in the PCT being studied (R9)**
He had been a Non-Executive member on the PCT Board since 2002. He was Chairperson for the PCT Safeguarding Children Group.

10. **Clinical Nurse Specialist Child Protection (R10)**
She was Clinical Nurse Specialist Child Protection in post for eight years and had worked in the PCT being studied (and predecessors) for over twenty years. Her background was health visiting. Her role involved supervising and supporting practitioners.

3.7.12 **Key Player Validation.**

Following analysis of the data from the Q sorts, two interviews were undertaken and an online discussion group held through the Royal College of GPs. This purposive sample sought to explore and challenge different aspects of the findings. They also sought to validate and illuminate the key factors
emerging from the data, to try to answer questions arising out of the data and to discuss findings with key people also undertaking work in relation to safeguarding children in primary care outside the county being studied.

1. Director of Primary Care and Public Involvement in the PCT being studied.

She was initially approached to participate in the Q-sort but did not reply. Several months later, she wrote apologising and expressing an interest to be involved; however the Q-sorts had already been completed. In analysing the data of the Q-sorts, it became apparent some statements generated a lot of discussion around the GMS Contract, GP Commissioning and the Quality and Outcomes Framework. This Director was the lead on these subjects for the PCT and agreed to be interviewed. The statements that generated discourse around the above topics were also shown to her and comments sought. This interview was very valuable in answering questions left unanswered through the data collection and confirmed and further illuminated key factors developing from that aspect of the study.

2. A Safeguarding Advisor in a key Governmental Department.

She has a high national safeguarding profile, leading and driving policy. She was approached at a conference and agreed to be contacted at a later date to discuss the study findings. This interview was valuable as it allowed the subject matter of this study to be discussed in a wider policy context.

3. An on-line discussion group through the Royal College of General Practitioners.

Following interview 2 it was viewed important to gain a wider perspective from GPs to the phenomena being studied and to further explore some issues identified in the literature review. Throughout the period of research, contact was maintained with the Safeguarding Lead of the Royal College of General
Practitioners (RCGP), with the aim of an interview to discuss findings. However, by 2006, she was no longer in post but maintained strong links with the RCGP through an on-line discussion group for GPs with special interests in safeguarding children. A briefing paper was prepared and an on-line discussion was initiated to discuss the issues and findings of the study and explore if other models existed similar to the Prime worker role. The participants were self-selected and following the introduction letter, led the on-line discussion. This reduced potential bias and researcher’s influence, although it is acknowledged these were already GPs with special interest in child protection and that their views were not generalisable to all GPs.

3.7.13 The Sort

The Q-sorts all took place at the participants workplace. At the time of arranging the appointment, it was identified a room enabling privacy and a large table on which to complete the sort would be required.

An information sheet was provided and participants given the opportunity to ask questions. If satisfied with the information given, they were invited to complete a consent form (appendix 5). Participants were reminded it was their own particular viewpoint being sought and there was no right or wrong answer to any questions or ‘correct’ way of placing the cards. Placing a ‘condition of instruction’ sheet by the participant during the sort reinforced the verbal instructions given (see appendix 7). The participants sorted four sets of statements; however they were not informed of the topic category being sorted. All participants agreed for the sorting process to be audio taped and were encouraged to make comments and elaborate on their viewpoint throughout the sort. On completing the sorting of each set of statements, the participants were prompted to review the siting of the statements and make changes if they wished. The aim of this was to support the reliability of the researcher’s interpretation of the sorting (Stainton Rogers 1991). The participants were also invited to make any comments in a brief post-sort
interview. All of the Q-sorts in this study were researcher-administered. Everyone who took part in the Q-sort managed the task without problems and all sorts were completed.

3.8 Data analysis.

An inductive approach to analysis was undertaken in order to discover factors and themes emerging from the data. It was important to select data analysis that would combine quantitative and qualitative methods used in this study. The method of data analysis described by Miles and Huberman (1994) was followed; data reduction, display and data conclusion. With this stance, conclusions about the meaning of the data collected, noting patterns and regularities begin from the start and these are then firmed up and verified. This was a continuous process through the analysis as different ways of exploring the data were sought, building on the theoretical propositions that led to and guided this study (Yin 1994:103). The analysis was designed to identify different sorting patterns and examined in order to infer what particular story was being told by each one (Stainton Rogers et al. 1995). An 'immersion approach' to qualitative data analysis was undertaken as described by Robson 2002:458) and reference to Burnard's (1991) method of analysing interview transcripts was followed.

Karim (2000), Polit & Hungler (1999:395) describe the analysis of data obtained through Q-sorts as being somewhat controversial. The options ranging from the most elementary, descriptive statistical procedures, such as rank ordering, averages and percentages to highly complex procedures such as factor analysis. In this study, a free-sort was viewed as the most appropriate sorting approach and this is incompatible with factor analysis. Block (1961) and Watts & Stenner (2005) argue against using factor analysis. Block (1961:11,92) maintains that the Q-sort method stands alone in its own right as a valuable scaling technique with no necessary relation to factor analysis and 'only occasionally will a statistical basis for inferring the importance of different item
placement be desired. Bolland (1985) argues the correlation model of data analysis is inadequate when a free-sort is used as it continues to mask individual differences in the location and shape of participant’s implicit distribution of beliefs.

Brown (1971:286) proposes most of the statistical information is contained in the item ordering, and factor types in Q-technique studies will be considerably more influenced by ordering preferences than they will be by distribution preferences. Therefore, it was viewed as important to initially focus on descriptive statistical findings. The use of factor analysis was explored but as the main focus of this study is qualitative and as it was noted from the literature a number of researchers are seeking alternative approaches to analysis (Lovemore 1989, Mercer 2006, Stenner et al 2007), the method of qualitative analysis was viewed as more appropriate to this study.

In this study, descriptive statistics provided initial data reduction and demonstrate significance in the sorting. Descriptive statistical analysis also helped with initial reduction of the qualitative data and teasing out of themes. The factors emerging from the Q-sort data were grouped with the taped discourse to further illuminate the key issues emerging as advised by Q-methodology expert Steven Brown (personal communication May & June 2006). The second stage of analysis was to explore if there were any differences or patterns in the data relating to those working in the PCT being studied with those working in child protection. The focus on qualitative data analysis is closely linked to the interpretative paradigm of this study.

3.9 Preparation of data for analysis

The Ordinal data from each sort was entered onto a record card (that reproduced the Q-sort distribution) at the time of each sort (see appendix 8). The data from the cards was then entered onto an Excel spreadsheet. Sheet 1 recorded the raw data from the record card (i.e. –5 to +5). This allowed
analysis of data within each category and against each participant response. Sheet 2 recorded the data giving each ranking a number (-5=11, -4=10, -3=9 etc). This provided data matrix sets and a framework for more detailed analysis of the data. A Q-method analysis package was obtained and considered, but this was not compatible with the free-sort technique of data collection.

<table>
<thead>
<tr>
<th>Siting</th>
<th>-5</th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>+4</th>
<th>+5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

Figure 3.3. The value attributed to each site on the continuum to give an individual sort card score.

An external validator checked the data from the record cards had been correctly entered onto the spreadsheet. Although this was very time consuming, it was viewed as being important due to any errors in entering data would invalidate findings. The validator dated and signed each record sheet in order to provide an audit trail if required. Several incorrect entries were found and corrected. There was no missing data as each sort card in each Q-sort had been given a ranking by all the participants.

Data were explored in different ways:

1. An overview of the results of all four categories in the sorting process using basic descriptive statistics of highest score, lowest score and mean.

2. An overview or results of the sorting process by category to include identification of top and bottom sort cards and those most widely distributed.

3. Data were explored in two groups which also incorporated the discourse of the participants - those who worked in the PCT being studied and those who worked in safeguarding children. Of the 10 participants, two worked in both and they were used to further explore and make comparisons.

Biographical information about the participants was used to explore whether or not configurations were related to a participant location. The summary
discourse of the interviews undertaken in respect of key player validation was explored and the findings of the GP email discussion group. All sources of evidence were reviewed and analysed together, so findings of the study are based on the convergence of information from different sources.

Following each meeting with the participants in the study, the researcher transcribed the taped discourse of the Q-sorts and interview data immediately. This was in order to maintain anonymity of participants and to support data immersion. Individual transcripts were printed on different coloured paper and coded. The full transcripts have not been included within the study but are available for reference. A manual method of coding was deployed as described by Burnard (1991).

3.10 Limitations and delimitations:

Brewerton and Millward (2001) propose Q-sort has many advantages. It is enjoyable for participants to complete so long as it is meaningful to them. It requires a relatively small sample of people to get reliable results and therefore minimises cost. Stainton Rogers (1995:183) identifies the data is highly reliable as it is either drawn from literature or from the perceptions and opinions of 'experts' and Q-methodology offers a robust approach to research. Polit & Hungler (1999) describe the technique of Q-sort as being versatile and can be applied to a wide variety of problems. Sorting cards may be a more favourable and less daunting method for participants than interviews. It has the power to surprise as no assumption about the way understandings are structured is built into the method (Cross 2005a,b).

Limitations may be the sorter refuses to sort all the cards. Like other 'scales' Q-method relies for its effectiveness and cooperation and frankness of the participant. The method is time consuming, particularly generation of statements. Although the Q-sort can be undertaken via post or e-mail, researchers have found this problematic (Steelman & Maguire 1996); therefore
face-to-face contact with participants involves travel and time. The methodology is relatively unknown and may be unfamiliar to participants; however the researcher ensured clear instructions were provided and was present during the Q-sorting to help with any queries that arose. This was viewed most important as validity can be affected if participants' lack of comprehension leads to misrepresentation. The time consuming process of Q-sorting could have been alleviated by use of focus groups which allow various participants to arrange statements on several Q-sort frames at the same time. However, much qualitative data obtained may be disregarded when a focus group is conducted which would make results of the Q-sorting less effective where there is a strong qualitative focus to the study (Denzine 1998).

3.11 Ethical considerations.

The study was conducted within an ethical framework drawn from Robson (2002). This emphasises identification between researcher and subject within a relationship of mutual trust, empathy, collaboration and commitment. Adherence to the researcher's Code of Professional Conduct was maintained at all times (Nursing & Midwifery Council 2002). Consideration was given to the psychological consequences of participating in research. Following data collection, the participants were given the opportunity to 'debrief' and if required to discuss issues arising with a designated specialist. The pilot was key to addressing any potentially difficult and sensitive issues at the earliest opportunity. Consideration was given to 'what it would be like to participate in this study' through constant reflection on the processes being undertaken with support and guidance from supervisors and experts in the field of Q-methodology. This research project did not involve working with vulnerable groups i.e. children, elderly or any form of 'captive group' (students) and the study did not require access to patients or records.

Ethical issues were considered in relation to the role and position of the researcher within the organisation being studied. Throughout the period under
study, the researcher's status within the organisation changed and this could potentially have had an influence and impact on the participants and the subjectiveness surrounding their personal beliefs and perspectives. The researcher is satisfied the method of data collection selected enabled participants to display a particular viewpoint on an issue of subjective importance, without being unduly constrained by the researcher's viewpoint. A method focusing on interviews could more likely produce a regurgitation of policy from the senior staff being asked to participate in the study. Using a focus group to select the final number of statements reduced potential for researcher bias in selecting the statements.

3.12 Consent.

Permission to undertake the study was obtained from the Chief Executive of the PCT being studied. Consent was sought from managers of those asked to participate. All participants in the study were asked to sign a consent form after being fully informed of the research study and given the opportunity to clarify any issues (see appendix 5) and to withdraw from the study at any stage. The procedure for informed consent followed the four elements as defined by Diener and Crandall (1978) cited by Cohen and Manion (1994:351) of competence, voluntarism, full information and comprehension. During the Sort, participants were asked at the halfway stage, 'are you happy to continue?' On completion of the meeting, participants were asked if there was anything about the process they wished to discuss.

Ethical approval to undertake this study was obtained from the Local Research Ethics Committee. Minor clarifications were required in order to proceed. Approval was also obtained from the University Ethics Committee, County Council Ethics Committee and the County Child Protection Advisor. Approval was obtained from the Research Governance Approval and Monitoring Consortium. Due to issues of anonymity and confidentiality, approval letters are not included in the appendix but are available.
3.13 Confidentiality.

All data obtained was stored securely and all participants in the study were assured of confidentiality of all information received. Privacy was sought on each occasion of data collection. The researcher transcribed and analysed all data to assist in the participants being anonymous to all but the researcher. Participants were given a letter informing them that total anonymity of information through the methods of data collection chosen could not be expected, but could be maintained during analysis and by use of coding. The different groups were still able to be identified and this allowed the topic in question to be answered in context. The sample consisted of specialists who could be easily recognised; therefore particular care was given to assuring anonymity of the PCT and locality participating in this study with respect to dissemination of the research findings. Locating the area as 'a PCT in the UK' throughout the study facilitated this. The PCT re-structuring has assisted in maintaining anonymity and confidentiality as the PCT studied no longer exists and by August 2007, only 3 participants of the Q-sort were still in post.

3.14 Conclusion.

This chapter has discussed the theoretical and philosophical perspectives underpinning the research. The design of the enquiry and justification for the particular choice of method has been explored. An overview of the Q-methodological approach has been presented with an explanation as to how the concourse and final statements were selected and prepared for the Q-sort. Discussion in relation to expert validation and participant selection has been discussed and ethical issues considered during the study explored. Justification for how the data was prepared and analysed has been presented.

The following two chapters present the results and illuminate the emergence of themes and patterns relevant to answering research questions of this study.
Chapter 4 RESULTS (1)

4.1 Introduction to chapter

This chapter presents the findings of the study. The strategy used to analyse the data was the categories identified through the literature review (which had been corroborated by the focus group in selecting the final sort statements), commenced with a general analytic technique that prepared data for more in-depth analysis and theory building in relation to the participants being studied.

In this chapter the data have been explored through:

1. An overview of the results in all four categories in the sorting process using basic descriptive statistics of highest, lowest and mean score.
2. An overview of results of the sorting process by category to include identification of top and bottom three sort cards.

Chapter 5 further explores the data by looking at participants through those that worked in the PCT being studied and those who worked in safeguarding children and presents the findings of the interviews and on-line discussion group.

All sources of evidence were reviewed and analysed together, so that findings of the study were based on the convergence of information from different sources. Interviews and discussions were undertaken during the analysis phase of the study in order to explore different aspects of the findings. Discourse is included to corroborate and illuminate the data from the sort. Charts have been included to visualise any patterns or differences noted within the categories, individuals or within the group. Full transcripts are available but not included. Virtually all discourse has been used.

Note to reader:
A laminated sheet providing the statements used in the sort has been supplied to ease the reader in following the results and discussion chapters. It is located at the back of the study.
4.2 An overview of the Q-method results.

The statements generated for the sort were designed with the aim of seeking to ensure the fullest range of viewpoints in the Q-sort deck. There were no predictions made prior to the sort where the majority of cards would be placed. Table 4.1 provides an overview of the participants and the number of cards placed in the +1 to +5 range (most agree), the number of cards placed in the -1 to -5 range (least agree) and the number placed at '0' (no view).

<table>
<thead>
<tr>
<th>Participant</th>
<th>Number of cards sorted in +1 to +5 range /85.</th>
<th>Number of cards sorted in -1 to -5 range /85.</th>
<th>Number of cards sorted at Zero.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>65</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>63</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>3</td>
<td>67</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>61</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>58</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>59</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>51</td>
<td>25</td>
<td>9</td>
</tr>
<tr>
<td>8</td>
<td>63</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>46</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>10</td>
<td>73</td>
<td>12</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 4.1 Overview of the distribution of sort cards by participant.

All participants placed at least 50% of the sort cards in the +1 to +5 end of the continuum with 5 participants placing 75% sort cards in the +1 to +5 range (63 cards or more). It is interesting to note Participant 10 who was Clinical Nurse Specialist, Child Protection in the PCT being studied, placed 73/85 cards in the +1 to +5 range (most agree). This participant appeared to have clear and strong views on how staff should be supported in primary care in relation to child protection. Whereas, Participant 9 who was a Non-Executive Director in the PCT only placed 46/85 cards between +1 and +5 and most (n=14) at 'no opinion'.

Participant 7 (Strategic Health Authority) and Participant 9 (Non-Executive Director) placed the most cards (n=25/85) between -1 and -5 (most disagree), whereas Participant 2 (Integrated Service Manager) placed the least (n= 9/85) in the -1 to -5 range. Participants 9 and 2 placed the most cards on '0' (no opinion / view) with Participant 9 placing a total of 25/85 statements in the 'little or no opinion range'.

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In the next chapter, further comparisons will be made in relation to those who worked in the PCT being studied and those who worked mainly in safeguarding children.

The data in table 4.2 presents an overview of the highest and lowest score in each category by participant. The mean scores in each category by participant are also presented. All numbers have been rounded to 1 decimal point. It is acknowledged that in such a small sample there are limitations to using median and mode scores and they may not be so significant. The maximum score for any card sited could be 11 (strongly agree). The minimal score could be 1 (strongly disagree).
<table>
<thead>
<tr>
<th>Participant</th>
<th>Responsibilities</th>
<th>Communication</th>
<th>Roles</th>
<th>Working Together</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>9.1</td>
<td>9.1</td>
<td>7.3</td>
<td>6.9</td>
</tr>
<tr>
<td>Participant 2</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>9.4</td>
<td>8.4</td>
<td>7.0</td>
<td>8.2</td>
</tr>
<tr>
<td>Participant 3</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>9.4</td>
<td>9.4</td>
<td>8.1</td>
<td>8.7</td>
</tr>
<tr>
<td>Participant 4</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>9.3</td>
<td>9.6</td>
<td>5.8</td>
<td>8.7</td>
</tr>
<tr>
<td>Participant 5</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Minimum</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>7.8</td>
<td>7.6</td>
<td>7.1</td>
<td>6.9</td>
</tr>
<tr>
<td>Participant 6</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>8.5</td>
<td>7.6</td>
<td>7.1</td>
<td>7.6</td>
</tr>
<tr>
<td>Participant 7</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Mean</td>
<td>7.8</td>
<td>7.2</td>
<td>6.3</td>
<td>7.9</td>
</tr>
<tr>
<td>Participant 8</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
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<td>3</td>
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<tr>
<td>Mean</td>
<td>8.0</td>
<td>8.8</td>
<td>6.8</td>
<td>8.3</td>
</tr>
<tr>
<td>Participant 9</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>9</td>
<td>10</td>
</tr>
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<td>Minimum</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mean</td>
<td>7.8</td>
<td>7.2</td>
<td>6.0</td>
<td>5.9</td>
</tr>
<tr>
<td>Participant 10</td>
<td>Responsibilities</td>
<td>Communication</td>
<td>Roles</td>
<td>Working Together</td>
</tr>
<tr>
<td>Maximum</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>10.2</td>
<td>9.3</td>
<td>7.3</td>
<td>10.2</td>
</tr>
</tbody>
</table>

Table 4.2. Data matrix presents the maximum, minimum and overall mean of each Q-sort for all participants in all 4 Categories.

For example, the above table demonstrates that Participant 1 gave the maximum score of 11 (most agree) to some of the statements in all four categories. R1 gave the minimum score of 1 in three categories, but did not have such strong disagreement to the statements around ‘responsibilities’ – with a lowest score of 4/11. The mean row identifies the average score for each category i.e. 9.1/11 for the category ‘responsibilities’.
4.3 Introduction to the Participants and scene setting.

Participant 1 was lead Director for Child Protection in the County being studied. She was very thoughtful before placing the cards in their final place. Explanations were given constantly throughout as to why cards were being placed for example in +3 ... 'I'm going to have to put it there ... yes ... however I'm finding it difficult ... I don't totally agree because ... '. She was confident in her knowledge of child protection policy but not so familiar with the Prime worker role. No statements were placed at 'O'.

Participant 2 was a senior member of staff working in Children & Young People's Service (formerly Social Services). He was keen to participate but felt uncertain at the start stating 'my knowledge of how GP surgeries deal with child protection will be limited'. He was given reassurance his own personal viewpoint was important and if he had no opinion or did not understand the statement, it should be placed at 'O'. He appeared to enjoy the process and made comments throughout the decision making process 'there are some I feel more passionately about than others ... I find this statement hard ... there is one quite interesting one here'. His mobile telephone rang during the sorting process. He apologised and asked if he could answer it. This was viewed acceptable as he was working in a role where he needed to be contacted anytime and was giving his time voluntarily. This interruption did not appear to disrupt the process or concentration and the sort was complete in 1 hour and produced the third longest transcript. Thirteen statements were placed at 'O'.

Participant 3 was a senior member of the Child Protection Unit in the County. She had vast knowledge and experience of working in child protection, but was not familiar with the concept of a Prime worker for child protection practice. She deliberated and debated over each statement before placing them and commented 'it's interesting that some are +5's and some are +4's, and I thought I'm not quite sure how I have made the distinction between the two really'. She reflected where the cards were placed and on several occasions moved them 'I have moved from +4 to +5 ... because I found that an interesting one for myself ... my value base ... because I think it is important ... and then I thought actually ...
Participant 3 stated she was not familiar with GP or primary health care teamwork arrangements and placed those cards at 0 or either side of 0. Statements were placed between numbers on several occasions and she was asked to consider ‘are these -3’s or -4’s? … kind of 4’s … ok then, -4’. Four statements were placed at ‘0’.

Participant 4 was a GP who was also the Clinical Lead for Clinical Governance in the PCT being studied. He had first hand experience of working with the Prime worker role in practice. Again, he needed to be reminded several times statements should be placed clearly within a response and not straddle two i.e. He wanted to place a card +4.5 and was encouraged to review it to +4 or +5. He also needed to be constantly reassured ‘your own particular viewpoint’ was required. Being a clinician in primary care, there were some stark differences in view points than those participants working solely at a strategic level and this has been explored in the analysis and discussion (statement 63R, 65R). Participant 4 made comments throughout ‘thinking aloud’ and appeared to enjoy the process … ‘mmm I’ve got an interesting spread… a very interesting process … I enjoyed looking at it’. The sort was completed in 1 hour. Three statements were placed at ‘0’.

Participant 5 was the most senior participant from the PCT being studied. She was the quickest and most confident in sorting the cards, although initially she commented several times ‘I’m worried that I don’t disagree’. She gave a very widespread range of where statements were placed. Seven statements were placed at ‘0’. The researcher sensed she was used to looking at a lot of information and making quick decisions. This sort was completed in 45 minutes. She quickly wanted to focus her comments on the statements not placed at the extremes ‘because I don’t know what the answer is’. This was in contrast to all the other participants who focused their comments around those strongly agreed with or disagreed with. This participant was most inspiring to listen to as she discussed her reasoning behind where the statements were placed. She was quite explicit about why a certain statement was +4 and not +5 etc. She immediately questioned when she was absentmindedly given the wrong set of
cards to sort again. She commented on how interesting it was to participate in the sort and the fourth set of cards (working together) an interesting set.

Participant 6 was the lead Director for Child Protection in the PCT being studied and stated the process of sorting the cards had triggered her to question some systems in practice ... 'and this has raised a question for me as to how we are sharing information with GPs and that’s a question I’ll take out of this morning'. Like many other participants, many statements were placed between numbers stating 'do they HAVE to be one or the other? Can’t they be half? Throughout the sorting process, this participant really took time to consider each statement thoroughly and appeared comfortable with giving a personal perspective. The sort was completed in 50 minutes and produced the second longest transcript. Four statements were placed at '0'.

Participant 7 was the Strategic Health Authority lead for Safeguarding Children. She had extensive knowledge and understanding of key and current child protection policy, legislation and strategic overview. However, she was totally unfamiliar with the concept of Prime worker or lead professional in GP Practices to co-ordinate child protection issues. The sort was completed in 50 minutes. Nine statements were placed at '0' and this sort had the highest number placed around −1 to +1 (27).

Participant 8 was a Public Health Director in the PCT being studied and stood throughout the sorting of her Q-sort cards. As researcher, this made me feel uncomfortable and I asked her several times during the sorting process 'are you sure you don’t want a chair? This was the most challenging participant who constantly questioned the meaning in the statements and 'what do you mean by this one? ... I agree with the second bit more than the first bit of that statement... I’m making judgements ... it’s very subjective' ... the constant challenging that followed led the researcher offering to cut up one statement into two halves (realising that in reality it would then be void). Fortunately this was not required and the participant chose to place the statement in the most disagree (-5). This participant appeared to struggle with the subjectivity and 'your own personal viewpoint'. During the sorting, the researcher was required
more than with any other participant to respond to questions asked and the response most often was 'if it is unclear to you, put it in '0'. Prior to sorting the third set of cards she said she needed to listen to a voicemail. The participant had very strong views and appeared to be interested in the sorting process, particularly with the fourth set of cards (working together), where her comments were more positive and less challenging 'I like that ... this is an interesting one ... this is true'. This participant had extensive research experience and at the end of the sorting questioned how the data would be analysed. The Sort was completed in 45 minutes. One statement was placed at '0'.

**Participant 9** was a Non-executive Director in the Primary Care Trust being studied. He had a background in medical research. He stated he was pleased to participate and gave consent to record the meeting. He was the only participant who did not make any comments during the sorting process even when invited at the end of each Sort category. He studied the statements and confidently placed them and did not change or move any. This was the shortest sort, which took 40 minutes. Twelve statements were placed at '0' with 25 placed around −1 to +1.

**Participant 10** has vast experience working in child protection and was the participant most familiar with the role of the Prime worker in GP Practices. She was extremely confident in her responses and was the participant most vociferous and placed the most cards at the extremes. No statements were placed at '0'. Clear reasoning was given to why statements were sorted in their final positions. She needed to be reminded that statements could not be placed to straddle two sitings. This participant reported enjoying the sort process and commented how thought provoking it had been. This was the longest sort which took 1 hour 15 minutes and produced the longest transcript.
4.4 Results of sorting process by category.

4.4.1 Category One - Responsibilities (Code A)

This category had 24 sort cards (card 21 was repetitive and removed prior to pilot).

The maximum mean score for a sort card in this category was 10.6/11
The minimum mean score for a sort card in this category was 2.2
The overall mean score for this category was 8.7

All participants placed at least one card on +5 (value 11).
6 placed at least one card on −5 (value 1).

The maximum score possible could have been 110 for any statement. This category had seven cards scoring 100 or higher. In comparison, there was only one card scoring significantly low at 22, the second lowest score being 50. The highest and lowest and scoring cards will be discussed in the next section.

The following table identifies the highest and lowest scoring cards in this category by participant. The siting column identifies, where on the continuum the highest and lowest scoring statements were placed. Statements that were sorted by more than one participant as highest have been printed in blue and lowest in red to indicate some degree of consensus between participants.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Highest score card numbers</th>
<th>Siting</th>
<th>No. in sort site</th>
<th>Lowest score card sitting</th>
<th>Score / Siting</th>
<th>No. in sort site</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4,5,10,16,20</td>
<td>11/+5</td>
<td>5</td>
<td>19</td>
<td>4/-2</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>4,5,9,10,12,17,20,22,23,25</td>
<td>11/+5</td>
<td>10</td>
<td>14</td>
<td>1/-5</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>4,5,7,10,11,13,16,17,18,19,20,22,23,25</td>
<td>11/+5</td>
<td>14</td>
<td>14,15</td>
<td>2/-4</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>2,3,4,6,9,10,11,12,15,17,18,20,23,25</td>
<td>11/+5</td>
<td>14</td>
<td>14</td>
<td>1/-5</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>4,9,18,23,25</td>
<td>11/+5</td>
<td>5</td>
<td>19</td>
<td>1/-5</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>15</td>
<td>11/+5</td>
<td>1</td>
<td>14</td>
<td>2/-4</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>1,2,9,15,23,24</td>
<td>11/+5</td>
<td>6</td>
<td>13,14,19</td>
<td>1/-5</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>4,10,11,15,16,17,20,25</td>
<td>11/+5</td>
<td>8</td>
<td>14,24</td>
<td>1/-5</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>9,15</td>
<td>11/+5</td>
<td>2</td>
<td>14</td>
<td>3/-3</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>1,3,4,5,7,8,9,10,11,12,13,15,16,17,18,20,22,23,24,25</td>
<td>11/+5</td>
<td>20</td>
<td>14</td>
<td>1/-5</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.3 The highest and lowest scoring statements per participant in Responsibilities Category.
The above table demonstrates participants strongly agreed to more statements in this category than they strongly disagreed with. Participants 10, 3 and 4 sorted the most cards in the +5 (most agree) site respectively. This was interesting as these participants were working closer to clinical 'grass-roots' level than the other seven participants. Eight cards were identically sorted 4, 10, 11, 17, 18, 20, 23, 25 in these participants.

Participant 7 sorted the highest number of strongly disagree statements. Statement 14 was one of the least agreed with statements in 9/10 participants, with a mean score of 2.2 and relates to commissioning GPs to ‘opt into’ child protection. It was a surprising response to question 14 from Participant 1 and leads to the question of whether the statement was clearly understood. Statement 4 and 9 were the highest scoring cards with a mean score of 10.6 and 10.5 respectively and relate to protecting children should ‘not be left to professionals alone’ and support is requirement for staff in order to fulfil their safeguarding role.

There were four statements that scored as highest scoring and lowest scoring across participants – 13, 15, 19, 24. In this category, there were also few participants giving zero rating (no opinion). This demonstrated the participants overall had strong views relating to statements around responsibilities. Statements that had the highest and lowest overall scores also corresponded to numbers of participants giving highest and lowest individual ratings. It was not an unexpected finding to the researcher that participants were familiar and had strong views around their responsibilities. All would be familiar with the Children Act 2004 and Laming recommendations (Laming 2003).
Graph 4.1 Overview Graph of the Category 'Responsibilities'.
The graph visually summarises the overall findings in relation to the sort Category Responsibilities. The different colours represent each participant (i.e. yellow = participant number 10). The bars represent each statement score (i.e. statement 4 scored 106/110). The thickness of individual coloured lines visualise the weight given to each statement. Statement 21 was removed from the sort prior to pilot and is not depicted in the graph. The graph visualises the general consensus over statements 4,5,20 and 22. The graph visualises that in this category there were more statements placed towards the 'most agree' and clearly visualises statement 14 as being the statement 'most disagreed' with.
This category had 18 sort cards.

The maximum mean score for a sort card in this category was 10.8/11.

The minimum mean score for a sort card in this category was 2.0.

The overall mean score for this category was 8.4.

All participants placed at least one card on +5 (value 11).

4 participants placed at least one card on -5 (value 1).

The maximum score possible could have been 110 for any statement. In this category, most cards showed a fairly similar spread of scoring demonstrating consensus to either mostly agree or disagree and highlights the importance of communication within the PCT and across agencies. This category had seven cards scoring 100 or higher. There were two statements scoring significantly low at 20/110 and 27/110. There was however less variation between maximum and minimum scores than other categories and this is further explored in chapter 5.

The following table identifies the highest and lowest scoring cards in this category by participant. The sitting column identifies, where on the continuum the highest and lowest scoring cards were placed. Cards that were sorted by more than one participant as highest have been print in blue and lowest in red to indicate some degree of consensus between participants. Points of significance will be briefly discussed.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Highest score card numbers</th>
<th>Siting</th>
<th>No. in sort site</th>
<th>Lowest score card sitting</th>
<th>Score Siting</th>
<th>/</th>
<th>No. in sort site</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<td>11/+5</td>
<td>6</td>
<td>29</td>
<td>1/-5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>26,35,36,38,40,41</td>
<td>11/+5</td>
<td>6</td>
<td>29,33</td>
<td>2/-4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>26,35,36,37,38,39,40,41,42</td>
<td>11/+5</td>
<td>10</td>
<td>29</td>
<td>1/-5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>26,27,28,32,35,36,37,38,39,40,41,42</td>
<td>11/+5</td>
<td>12</td>
<td>29</td>
<td>2/-4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>35,38,41</td>
<td>11/+5</td>
<td>3</td>
<td>29,32,33</td>
<td>1/-5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>38,41</td>
<td>11/+5</td>
<td>2</td>
<td>29</td>
<td>2/-4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>36,38,39,40,41</td>
<td>11/+5</td>
<td>5</td>
<td>31,32,33,37,42</td>
<td>4/-2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>26,27,38,40,41</td>
<td>11/+5</td>
<td>5</td>
<td>29,33,39</td>
<td>3/-3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>26</td>
<td>11/+5</td>
<td>1</td>
<td>29</td>
<td>2/-4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>27,34,35,36,37,38,39,40,41,43</td>
<td>11/+5</td>
<td>10</td>
<td>29,33</td>
<td>1/-5</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.4 The highest and lowest scoring statements per participant in the Communication category.
The above table demonstrates participants strongly agreed to more statements in this category than they strongly disagreed with. Participants 4, 3 and 10 again sorted the most cards in the +5 (most agree) site. This was interesting as these participants were working closer to the clinical 'grass-roots' level than the other seven participants and seven cards were identically sorted - 35,36,37,38,39,40,41. Participant 5 sorted the highest number of strongly disagree statements. Statement 29 was one of the least agreed with statements in 9 out of 10 participants with a mean score of 2 and relates to strongly held views that communication is not good within primary care and that the role of Prime worker is needed. Statement 33 with a mean score of 2.7 also had strongly held views; communication with other agencies was a problem for GP practices.

Statement 41 and 38 scored +5 (value 11) in 9 out of ten participants with a mean score of 10.8 and 10.6 respectively and reinforces the importance of communication across agencies. Statement 41 was the highest scoring statement in the whole sort (108/110) and reiterates current research and literature in relation to the impact of poor communication on the outcomes for children. Three statements (32, 37 and 42) were sited as the highest and lowest scoring statements by different participants and these all relate to participants perspectives on the impact of frequent organisational change and will be explored further. In this category, there were also very few participants giving zero rating (no opinion). This demonstrated the participants overall had strong views relating to the statements on communication.
Graph 4.2 Overview Graph of the Category 'Communication'.

The graph summarises the overall findings in relation to the sort Category Communication. The different colours represent each participant (i.e. yellow = participant 10). The bars represent each statement score (i.e. statement 41 scored 108/110). The thickness of individual coloured lines visualise the weight given to each statement. The graph clearly visualises that statement 41 was the highest scoring statement in the overall sort. It also visualises those statements where there was most consensus scoring (35, 36, 40, 41).
4.4.3 Category Three - Roles (Code R)

This category had 24 sort cards (card 46 was repetitive and removed prior to pilot).

The maximum mean score for a sort card in this category was 10.1/11
The minimum mean score for a sort card in this category was 2.7
The overall mean score for this category was 7.0

7 participants placed at least one card on +5 (value 11). 
6 placed at least one card on −5 (value 1).

The maximum score possible could have been 110 for any statement. This category only had one statement scoring over 100 and relates to the overall agreement that health visitors had a high degree of interest in child protection. Three statements scored significantly low with a mean score of 2.7/2.8 where participants generally disagreed child protection was the responsibility of the health visitor and the role of Prime worker was not needed. In this category there is a wide variation between the maximum and minimum scores for a few statements and the most diverse sitings will be discussed in the next chapter.

The following table identifies the highest and lowest scoring cards in this category by participant. The siting column identifies, where on the continuum the highest and lowest scoring statements were placed. Cards sorted by more than one participant as highest have been printed in blue and lowest in red to indicate some degree of consensus between participants. Points of significance will be briefly discussed.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Highest score card numbers</th>
<th>Siting</th>
<th>No. in sort site.</th>
<th>Lowest score card sitting</th>
<th>Score Sitting /</th>
<th>No. in sort site.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>56,60,</td>
<td>11/+5</td>
<td>2</td>
<td>48,49,67</td>
<td>1/-5</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>52,66</td>
<td>11/+5</td>
<td>2</td>
<td>68</td>
<td>1/-5</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>50,53,56,58,59, 62,66</td>
<td>11/+5</td>
<td>7</td>
<td>49</td>
<td>1/-5</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>45,47,51,52,58</td>
<td>11/+5</td>
<td>5</td>
<td>56,61,63,65,67</td>
<td>1/-5</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>58</td>
<td>11/+5</td>
<td>1</td>
<td>68</td>
<td>2/-4</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>50,51,52,58,59</td>
<td>10/+4</td>
<td>5</td>
<td>54,68</td>
<td>2/-4</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>59,64</td>
<td>10/+4</td>
<td>2</td>
<td>49,55,</td>
<td>3/-3</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>47,58,64</td>
<td>11/+5</td>
<td>3</td>
<td>54,68</td>
<td>1/-5</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>60</td>
<td>9/+3</td>
<td>1</td>
<td>56</td>
<td>2/-4</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>47,50,51,52,53,58, 59,62,65,66</td>
<td>11/+5</td>
<td>10</td>
<td>49,54,55,56,57, 60,68</td>
<td>1/-5</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 4.5 The highest and lowest scoring statements per participant in the 'Roles' category.
Again Participant 10 expressed the strongest views placing more sort cards at the extremes than any other participant. However, her sitting matches well with the overall highest and lowest scores of other participants. The discourse during sorting by Participant 10 clearly justified her decision-making process.

The above table demonstrates a more even spread to statements strongly agreed and strongly disagreed with. It is interesting to note less overall extreme sitting and this could indicate participants had less strong views around roles, or could indicate uncertainty. The researcher noted during the sort process and this was reflected in the participant discourse, that some were uncertain about the role of the Prime worker and the role of other professionals.

Participants 10 and 3 again sorted the most cards in the +5 (most agree) site. This was not unforeseen as it was expected they would have a clearer understanding of roles within child protection networks. Both worked within safeguarding but only one in the PCT being studied. Participants 4 and 6 also expressed strong views and this was also interesting as all these participants were working closer to clinical 'grass-roots' level than the other six participants. Six cards were identically sorted 50, 53, 58, 59, 62, 66.

In this category, there more participants sited within the 'no opinion' category and by far (n=52/240) the most placed within the little/no opinion (-1 to +1 range). It was interesting to the researcher to note that there was no clear divide in who placed most statements within the little/no opinion range. In trying to analyse this, it was evident that there was no clear link to those who worked in the PCT or those in safeguarding. There was however some surprise in that two key people in the PCT had placed a high number of statements at 'no opinion'.
Graph 4.3 Overview Graph of the Category ‘Roles’.
The graph visually summarises the overall findings in relation to the sort Category Roles. It visualises that there were less extreme views (or uncertainty?) to the statements in this sort category relating to ‘Roles’. The different colours represent each participant (i.e. yellow = participant number 10). The bars represent each statement score (i.e. statement 58 scored 101/110). The thickness of individual coloured lines visualise the weight given to each statement. The graph visualises consensus scoring in relation to statements 51, 54, 58, 62.
4.4.4 Category Four - Working Together (Code W)

This category had 19 sort cards.

The maximum mean score for a sort card in this category was 10.4/11
The minimum mean score for a sort card in this category was 1.6
The overall mean score for this category was 7.9

8 participants placed at least one card on +5 (value 11).
8 placed at least one card on −5 (value 1).

Many of the participants reported this was the most interesting set of statements to sort. The maximum score possible for any statement could have been 110. This category had five sort cards scoring over 100 but only one card scoring very low at 16. The lowest scoring statement in the whole sort was in this category – statement 81 ‘actually in my role we don’t do child protection’. This category had five statements with divisive scoring /− (+9 (20%) differences in scoring and will be discussed in the next chapter.

The following table identifies the highest and lowest scoring cards in this category by participant. The siting column identifies, where on the continuum the highest and lowest scoring cards were placed.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Highest score card numbers</th>
<th>Siting</th>
<th>No. in sort site</th>
<th>Lowest score card sitting</th>
<th>Score Siting</th>
<th>/</th>
<th>No. in sort site</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>69,70,71,74</td>
<td>11/+5</td>
<td>4</td>
<td>81</td>
<td>1/-5</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>69,70,71,73</td>
<td>11/+5</td>
<td>4</td>
<td>81</td>
<td>1/-5</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>69,70,71,72,73,74,75,76,77,80,85</td>
<td>11/+5</td>
<td>9</td>
<td>81,84</td>
<td>1/-5</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>69,70,71,72,73,74,75,76,77,80,85</td>
<td>11/+5</td>
<td>11</td>
<td>81</td>
<td>1/-5</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>69,85</td>
<td>10/+4</td>
<td>2</td>
<td>81,84</td>
<td>1/-5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>70,71,73,74,80</td>
<td>11/+5</td>
<td>5</td>
<td>81</td>
<td>1/-5</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>70,73,74</td>
<td>11/+5</td>
<td>3</td>
<td>75,76,77</td>
<td>5/-1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>69,71,74,83</td>
<td>11/+5</td>
<td>4</td>
<td>81</td>
<td>1/-5</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>76</td>
<td>11/+5</td>
<td>1</td>
<td>81,83</td>
<td>2/-4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>69,70,71,72,73,74,76,77,78,80,82,83,85</td>
<td>11/+5</td>
<td>14</td>
<td>81</td>
<td>1/-5</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.6 The highest and lowest scoring statements per participant in the ‘Working Together’ category.

The above table demonstrate participants strongly agreed to far more statements in this category than they strongly disagreed with. Participants 10, 4 and 3 again sorted the most cards in the +5 (most agree) site. Nine cards were
identically sorted 69, 70, 71, 72, 73, 74, 77, 81, 85 in all three participants. These statements focused mainly around the importance of meeting regularly and the health visitor's role in the PHCT.

Participant 7 gave the highest number of little/no opinion (n=8/19), including to statement 81. Interestingly, the statements 75, 76 and 77 were sited by Participant 7 at most disagree (-5), were sited at most agree (+5) by Participant 4. Participant 4 had strongly held views in respect of the impact of constant organisational change and serious concerns about health visitors being placed away from the PHCT.

Statement 81 was one of the least agreed with statements in 9 out of 10 participants, with a mean score of 1.6, the lowest statement card in the whole sort. There was a surprising response to question 81 from Participant 7 and leads the researcher to question whether the statement was clearly understood. Statement 70 and 73 were the highest scoring cards with a mean score of 10.4 and relate to the importance of effective communication and professional face-to-face contact.
Graph 4.4 Overview Graph of the Category 'Working Together'.

Graph 1 visually summarizes the overall findings in relation to the sort Category 'Working Together'. The bars represent each statement score (i.e., statement 81 scored 16/110). The graph clearly visualizes the weight given to each statement. The graph clearly visualizes statement 81 as the lowest scoring statement in the overall sort.
4.4.5 Reflection

Participants 3, 4, and 10 showed a fairly consistent sitting pattern across categories. This was not an unexpected result as they were working closest at clinical level, working with difficulties in communication, understanding roles etc. It was anticipated that Participant 4 and 10 would be the most familiar with the Prime worker role and indeed had strong views. Participant 10 had the most strongly held views with no sittings in the 'no opinion' and only 3 within the −1 to +1 (little opinion) sitting. In contrast, Participant 9 placed 37 within this range.

4.5 Identification of top and bottom Q-sort cards in each category.

This section will discuss the three top and bottom Q-sort cards. Discourse during the sort process has been included where appropriate, to illuminate findings of the sort. Words in capitals highlight the emphasis put on a word by the participant.

4.5.1 Responsibilities

All statements in this category focused on responsibilities in relation to safeguarding children within the primary health care team and included organisational i.e. PCT responsibilities.

<table>
<thead>
<tr>
<th>Statement number</th>
<th>Statements most agreed with.</th>
<th>Score / 110</th>
<th>Mean score for statement/ range</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Practitioners at all levels should be supported in their role of protecting children.</td>
<td>106</td>
<td>10.6 (9-11)</td>
</tr>
<tr>
<td>9</td>
<td>Protecting children cannot be left to the professionals alone.</td>
<td>105</td>
<td>10.5 (9-11)</td>
</tr>
<tr>
<td>23</td>
<td>Child abuse and neglect is one of the most serious health conditions affecting children ... it should be looked at as any life threatening illness.</td>
<td>104</td>
<td>10.4 (9-11)</td>
</tr>
</tbody>
</table>

Table 4.7 Responsibilities: The three statements scored the highest (most agreed with).

The overall high scores of this category made it difficult to just focus on the top three statements as statements 5, 25, 20 and 10 also scored high at 103/110, 101/110 and 100/110 respectively.
The significant consensus of statements 4 and 9 was not unexpected as it reflects current research, legislation and policy in that safeguarding children is everybody's responsibility, yet in order to achieve this, staff should be supported.

Statement 23 was interesting as it scored consistently high across all participants, acknowledging responsibilities and the high priority safeguarding children has for the participants in this study.

In comparison, there was only one statement (14) with a very low score. The participants demonstrated strong views to this statement. The discourse around these statements reflects this:

I totally disagree with paying GPs for child protection services ... this is an everyday business of every health professional... there should be no need for incentives ... its everybody's business. (R7)

It shouldn't be they CAN opt into ... they absolutely HAVE * to opt into it. (R10)

The thought of GPs opting into anything with regard to child protection issues is worrying. (R2)

... many of us in Executive roles in the NHS find this ... this issue that GPs will only do something if you give them money. (R8).

We have to get primary care to take child protection very seriously ... and that certainly would not be the way to do it giving them the option to opt-out. (R6).

<table>
<thead>
<tr>
<th>Statement number</th>
<th>Statement least agreed with.</th>
<th>Score / 110</th>
<th>Mean score for statement / range.</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>What is needed is for Trusts to commission child protection as a service that GPs can opt into.</td>
<td>22</td>
<td>2.2 (1-5)</td>
</tr>
<tr>
<td>19</td>
<td>The key child protection professional for each primary health care team needs financial incentive in order to undertake this role.</td>
<td>50</td>
<td>5.0 (1-11)</td>
</tr>
<tr>
<td>13</td>
<td>What is needed is for Trusts to commission child protection as a service in which GPs are given the time and money to prioritise it.</td>
<td>62</td>
<td>6.2 (1-11)</td>
</tr>
</tbody>
</table>

Table 4.8 Responsibilities: The three statements that scored the lowest (least agreed with).

* Denotes participant voice emphasis.
There was clearly a consensus from all participants to statement 14. However, there was a wider range with the next two lowest scoring statements which ranged from a score 1-11. The higher scoring for statement 19 came from participant 3 who stated:

*I moved this one from a +4 to +5 ... because I find that an interesting one for myself ... my value base because I thought it was important (R3)*

The higher scoring for statement 13 came from Participants 3 and 10. Both these participants worked exclusively in safeguarding children, one within the PCT and one from another agency. These statements with wide ranging scores are interesting and will be discussed in the next chapter.

### 4.5.2 Communication

All statements in this category focused on communication in relation to safeguarding children within the primary health care team and included organisational i.e. PCT responsibilities.

<table>
<thead>
<tr>
<th>Statement number</th>
<th>Statements most agreed with.</th>
<th>Score / 110</th>
<th>Mean score for statement/range.</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>Poor communication has been a significant factor in the historical failure to protect children from abuse and neglect.</td>
<td>108</td>
<td>10.8 (9-11)</td>
</tr>
<tr>
<td>38</td>
<td>Communication between staff in the same and different agencies is of paramount importance to ensuring the protection of children.</td>
<td>106</td>
<td>10.6 (7-11)</td>
</tr>
<tr>
<td>40</td>
<td>Effective communication relating to child protection is important at the interface of general practice.</td>
<td>104</td>
<td>10.4 (8-11)</td>
</tr>
</tbody>
</table>

Table 4.9. Communication: The three statements that scored the highest (most agreed with)

Statement 41 was the highest scoring statement scoring 108/110. Nine of the ten participants scored maximum of 11 (+5). The top three statements were not an unexpected finding but confirms the importance given to effective communication within primary care and also within health and across agencies in safeguarding children. Again, this category had a strong consensus apart from Participant 9 who gave the lower range score to each of the above statements.
This participant was the only person to sort without making any comments, even when prompted. It is therefore quite difficult to further explore reasons for score siting:

*Sharing information is KEY* ... between agencies ... as well as its importance within primary care ... the Prime worker is needed if it keeps child protection alive in primary care. (R7).

... I think it is our biggest problem (communication) ... it keeps coming up time and time again ... we are still not learning from it really. (R1.)

The most frustrating thing is communication ... I can't say enough about communication ... we are trying to shift the culture of practice and work effectively ... (R2)

<table>
<thead>
<tr>
<th>Statement number</th>
<th>Statement least agreed with.</th>
<th>Score / 110</th>
<th>Mean score for statement / range.</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>The role of Prime worker for child protection is not needed, as communication is already very good in primary care.</td>
<td>20</td>
<td>2.0 (1-5)</td>
</tr>
<tr>
<td>33</td>
<td>Communication with other agencies is not a problem in GP Practices.</td>
<td>27</td>
<td>2.7 (1-4)</td>
</tr>
<tr>
<td>31</td>
<td>Systems are in place to alert GPs how many vulnerable children there are in their Practice.</td>
<td>69</td>
<td>6.9 (4-9)</td>
</tr>
</tbody>
</table>

Table 4.10 Communication: The three statements that scored the lowest (most disagreed with).

There is an overall consensus towards disagree on statement 29 and 33.

*I totally disagree the role is not needed and communication is very good ... it wasn't very good ... and is why the Prime worker role was introduced ... and without it ... communication wouldn't be nearly as good as it is now ... communication is an absolutely ENORMOUS problem in GP practices (R10).*

*I think communication IS * a real issue ... it is very variable ... I put all the communication ones up there (points to +5) ... BUT* the one 'the role is not needed'... I don't believe that is the case ... 'communication with other agencies is not a problem'... I think it is. (R5)

*I wouldn't agree with that ... that communication isn't a problem with other agencies ... clearly it is a problem. (R2)*

*Denotes participant voice emphasis.*
I REALLY DO THINK * that primary care arent necessarily good at communicating ... sometimes not even good communication within practices ... and that is an issue we need to look at around protecting children. (R6).

Communication with other agencies ... it is always a problem ... so with the role of the Prime worker communication is as good as it can be. (R4)

Participant 7 reported not being familiar with the role of a lead child protection professional within primary care, and therefore felt unable to have a strong view. However, Participant 2, 3 and 9 were also not familiar but strongly disagreed with the above statements:

I think it is a minefield ... I can imagine there may well be huge difficulties ... communication with meaning and understanding is probably a HUGELY different experience. (R3)

There is still a huge variation in the response you get ... if there is no designated person ... reluctance to share information ... communication within and across agencies ALWAYS * been sighted as a common factor. (R2)

Although statement 31 was one of the lower scoring statements in this category, the score cannot be described as being a statement strongly disagreed with, as most of the sitings were around 'no or little opinion'. This is reinforced in the discourse where many participants were unsure if there was a system in place and those working outside the PCT were more likely to site 'no opinion':

Systems in place to alert GPs ... I'm not convinced ... I think there is a system ... I don't think it is used to it's best advantage ... and therefore for me a false sense of security. (R1)

Systems are in place but they are variable ... I think that is where the Prime worker is so essential ... do as much as possible to ensure the system is valid and used. (R10)

I have placed this here (+2) although I have a system to know about vulnerable children ... this has raised a question for me as to how we systematically share that information with GPs and a question I'll take out of today. (R6)

*Denotes participant voice emphasis.
4.5.3 Roles

All statements in this category focused on roles in relation to safeguarding children within the primary health care team. There was a particular focus around the role of a Prime worker for child protection.

<table>
<thead>
<tr>
<th>Statement number</th>
<th>Statements most agreed with.</th>
<th>Score / 110</th>
<th>Mean score for statement/ range.</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>Health visitors have a high degree of interest in child protection matters.</td>
<td>101</td>
<td>10.1 (8-11)</td>
</tr>
<tr>
<td>52</td>
<td>The role of lead professional in primary health care teams should be continued.</td>
<td>95</td>
<td>9.5 (5-11)</td>
</tr>
<tr>
<td>51</td>
<td>A child protection lead professional in GP practice has a role in coordinating training needs of all practice staff.</td>
<td>94</td>
<td>9.4 (8-11)</td>
</tr>
</tbody>
</table>

Table 4.11 Roles: The three statements that scored the highest (most agreed with).

The significant consensus of statement 58 was not surprising as it reflects their role of providing a universal service that ... ‘uniquely well placed to identify risk factors to children ... expertise in assessing and monitoring child health and development’ (DH 2000). Statement 58 (and similarly 47) was included to test out a generally held presumption health visitors have a high degree of interest and training in child protection. Bannon et al (2003) and Ling & Luker (2000) challenge this, yet these findings reinforce that presumption:

> Health visitors do have a high degree of interest in child protection matters ... they are often the first people aware families are in difficulty ... I would argue that it is ALWAYS the health visitor. (R10)

Statement 52 scored between 8-11 in 9/10 participants. There was strong agreement, even for those participants working outside the PCT being studied. This finding links to the two audits undertaken by the researcher in 2005, the outcome clearly being that staff working at the clinical level advocated the role should be continued. What was interesting was the participants although sited the health visitor, did not strongly agree this role had to be undertaken by a

* Denotes participant voice emphasis.
health visitor (Health visitor score 80/110, GP score 38/110, Anyone in the PHCT score 57/110):

... it ABSOLUTELY DEFINITELY* should be continued... we can still achieve more and get things better ... because it is right at the front ... the first line of contact with children. (R10)

Participant 7 sited ¬1 (score 5) to this statement and comments made questioned her understanding of a lead professional to co-ordinate child protection within primary care:

*I can see a need for co-ordinating ... training ... but to be perfectly honest that is down to individuals ... so then I struggle with the role ... to know whether you need a special person ... but if it keeps child protection alive within primary care... (R7)

Statement 51 also had a strong consensus from all participants. This finding reflects the notion all members of the PHCT need training at a level in keeping with their responsibilities and without the Prime worker question who could co-ordinate that:

Yes... the Prime worker ... lead professional does have an important role in co-ordinating the training needs of all the practice staff ... (R10)

<table>
<thead>
<tr>
<th>Statement number</th>
<th>Statement least agreed with.</th>
<th>Score / 110</th>
<th>Mean score for statement / range.</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>The organisation already has enough child protection specialists; therefore the role of prime worker for child protection within primary care is not required.</td>
<td>27</td>
<td>2.7 (1-6)</td>
</tr>
<tr>
<td>49</td>
<td>In GP practice, child protection is the responsibility of health visitors.</td>
<td>28</td>
<td>2.8 (1-7)</td>
</tr>
<tr>
<td>68</td>
<td>The PCT already have child protection specialists, therefore the role of prime worker for child protection within primary care is not needed.</td>
<td>28</td>
<td>2.8 (1-8)</td>
</tr>
</tbody>
</table>

Table 4.12 Roles: The three statements that scored the lowest (most disagreed with).

Statements 29 (communication), 54 & 68 were very similar and similarly sited with an overall score for each statement being 20, 27 and 28 respectively. The inclusion of very similar statements across categories was intentional as they

*Denotes participant voice emphasis.
were key to answering the research questions set. It was therefore interesting to note similarities in statement scoring and discourse (also refer to discourse on statement 29). Also, the strongly disagree statements in this category link to one of the most strongly agreed statements (52) in that the role should be continued:

... because there will be huge variation in the response you get when you call up ... delays ... no designated person ... reluctance to share information ... that's my perspective as an outsider ... a lead professional is HUGELY IMPORTANT*. (R2)

I think it is so integral to the role of somebody in the practice but it needs to be recognised as such ... (R8)

YES, IT MOST DEFINITELY IS REQUIRED* ... and it was research that showed it was required and why it was put into place and it is ABSOLUTELY needed. (R10)

I strongly disagree the role is not needed ... I know things are fairly variable in general practice and ... having somebody or at least practices KNOWING that they need somebody begins to raise the profile in areas where it isn’t getting the attention it needs. (R5)

Statement 49 links to statements 9 (score 105/110) and 81 (score 16/110) to test out perceived responsibilities for safeguarding children within primary care.

I DON’T* think child protection is the sole responsibility of health visitors ... I think it should be wider ... although they are the key professional. (R5)

I most disagree it’s just not the health visitors ... it’s everybody’s responsibility ... everybody in the PHCT. (R10)

4.5.4 Working Together

All statements in this category focused on Working Together in relation to safeguarding children within the primary health care team. Participants appeared to enjoy sorting this category and commented:

Mmm ... I’ve got an interesting spread ranging across the board this time. (R4)

They were a very interesting set. (R5)

*Denotes participant voice emphasis.
Table 4.13. Working Together: The three statements that scored the highest (most agreed with).

There was a strong consensus to the top four statements with all sittings being within the +1 (score 7) to +5 (score 11) range. This finding was not unexpected and relates to a subject that has been extensively researched around collaboration (Hallett 1995, Lupton et al. 2001, Morrison 2000). There was very little discourse apart from acknowledging the statements placed at the most agree were important.

The meetings ... I'm a strong believer in face-to-face where you might be sharing suspicion rather than facts ... trust is an important element ... if a team is not working cohesively there is a danger (R5)

These around ... meeting ... supporting ... this network which I think is vital ... this links nicely to 'health visitors should always be attached' ... is a dilemma we are going to have to tackle as we start to move ... more integrating ... and that is going to be a difficult to balance between practice relationships and the relationships with other agencies. (R6)

Discourse around Statement 69 was interesting for participants working within or closest to the delivery of patient care had the strongest views:

I strongly disagree that if health visitors are not based in practices ... look what has happened to our district nurses ... poor communication ... social workers in primary care teams ... please (R4).
Participants 2, 3, 7 and 9 working outside the PCT being studied, commented on not being familiar with the Prime worker role and this was also highlighted by Participant 10 as an issue that needed to be addressed:

> Yes it is MOST IMPORTANT * other agencies are aware there is a lead professional in GP practices ... I know we have made them aware but some child protection advisors were quite surprised about it ... we have a greater need to publicise the role ... (R10)

<table>
<thead>
<tr>
<th>Statement number</th>
<th>Statement least agreed with.</th>
<th>Score / 110</th>
<th>Mean score for statement / range.</th>
</tr>
</thead>
<tbody>
<tr>
<td>81</td>
<td>Actually in my role, we don't do child protection.</td>
<td>16</td>
<td>1.6 (1-6)*** SHA</td>
</tr>
<tr>
<td>84</td>
<td>The National Service Framework for Children minimum requirement of every Trust appointing a children's lead will draw GPs out of their silos.</td>
<td>45</td>
<td>4.5 (1-9)</td>
</tr>
<tr>
<td>79</td>
<td>One of the problems for GPs working in child protection is accessing training.</td>
<td>57</td>
<td>5.7 (2-11)</td>
</tr>
</tbody>
</table>

Table 4.14. Working Together: The three statements that scored the lowest (most disagreed with).

Statement 81 was the lowest scoring statement of the entire sort with 8/10 siting -5 (score 1) and one participant R4 (scoring 2). This was not an unexpected result but was included in the sort because the researcher was interested in the response from key people in a strategic position and links to the Laming recommendations (2003). Participant 5 was Chief Executive and did not hesitate in placing the card at most disagree and stating:

> I don't do face-to-face ... but if I don't think it is important it wouldn't happen very well ... it is part of my role ... it might not be a huge part but it is an important part. (R5)

However, again Participant 8 sited at '0' – no opinion. This was very surprising considering she had the Strategic lead in the SHA for Safeguarding. No comments were made around the placing of this sort card.

* Denotes participant voice emphasis.
Statement 84 was included in the sort because there was an underlying presumption in the literature studied the NSF would help to engage primary care in children’s services (DH 2004e):

*I'm not sure it will make any difference ... draw GPs out of their silos (laughs).* (R2)

... the NSF does not have enough emphasis on the safeguarding agenda in its broadest sense ... so I DO * think that there is a very important role for Prime workers ... (R1)

*Was the Government really thinking about GPs through the NSF? ... I haven’t been reading it with that view ... I can’t see it would happen personally ... its maybe the intention ... but I don’t think it is going to happen ...I don’t agree (laughs).* (R3)

Statement 79 was selected to test out the findings in the literature reviewed in relation to problems with GPs accessing training.

Participant 4 was a GP:

*Accessing training for GPs ... could be a problem in some areas although in this area we try to address it.* (R4)

*I don’t know if GPs have problems accessing training ... they might have a problem finding time ... but I would have HOPED * training is available.* (R5)

... but that is where the Prime worker is so helpful because she is in the practice and can undertake training ... it’s when things are done at a local level that’s often when they are most effective. (R10)

4.6 Conclusion to chapter.

This chapter has presented an overview of the results from the Q-sort process using descriptive statistics. Some of the discourse generated has been incorporated. Chapter 5 further explores individual participant sitings and the data through those working in the PCT being studied and those working in safeguarding children but not in the PCT being studied. The discourse generated during the sort is explored and the findings from the interviews and email GP discussion group presented.

* Denotes participant voice emphasis.
Chapter 5

5.1 Introduction to chapter

This chapter explores and compares views and perspectives of those participants who worked in the PCT being studied (n=4), with those working in safeguarding children but not in the PCT (n=4). Two participants worked both in the PCT and child protection was a substantive part of their role (R6 & 10). They will be discussed separately as there was a presumption these two participants were driving the safeguarding agenda of the PCT and their responses could be very different from the other participants.

Whilst exploring the data, it became clear there were some wide-ranging scoring statements. These are important to explore and to question whether there may be a difference in views between the groups described above. Comparisons are made exploring the findings and noting points of significance to answering the research questions of the study. The summary discourse of the participants and the interviews undertaken in respect of key player validation is explored. The findings from the GP email discussion group are presented.

The aim of this chapter is to explore the data further illuminating the emergence of themes, and begin to discuss the findings that will be elaborated in the next chapter.

5.2 Maintaining the Q-methodological approach.

Watts and Stenner (2005), critique some of the common misunderstandings of interpretation in using Q-methodology. It was at this stage in the analysis process, advice and guidance were sought from prominent researchers in Q-methodology (Block 2006, Brown 2006) in order to further analyse the data and maintain, enhance reliability and validity of the Q-method approach, yet maintain a strong emphasis and focus on the discourse and qualitative paradigm. Reference was also made to the work of Lovemore (1989) and Mercer (2006).
5.3 An overview of the sitings of the different groups.

5.3.1 Participants working in the PCT being studied.

Graph 5.1 visualizes an overview of the sitings for those working in the PCT. These participants included four of the most senior people: Chief Executive, Public Health Director, Non-Executive Director and a GP who was also the Clinical Governance lead and GP Tutor. There was a general consensus in the overall scoring although the GP (working at the Clinical level as well as strategic), and Chief Executive had some starkly differing views in relation to the impact of organisational change on communication. The GP also disagreed with many statements about GPs perceived role in and attitudes to child protection. He did however refer to his own GP practice where communication was good and the role of Prime worker working well and acknowledged it may not be so in other practices.
Graph 5.1 Participants working in the PCT being studied. Maximum score for statement could have been 44 (11x4).
Graph 5.2 visualizes an overview of the sitings for those working in safeguarding children, but not in the PCT being studied and include two senior people from Social Services, the SHA Safeguarding lead and lead Child Protection PCT Director in the County. There was a remarkable concordance to statements around 'Responsibilities'. In the 'Communication' category, there was general consensus apart from Participant 7 not agreeing with statements around the negative impact of organisational change on communication. There was a varied response within the 'Roles' category, however these participants were not so familiar with the Prime worker role or the concept of a lead professional in primary care – as was the presumption for those working in the PCT. There was general agreement to statements around 'Working Together', although there were various views as to whether the health visitor should be attached to GP practices.

It was not unexpected those working outside the PCT were less familiar with the role of Prime worker, but all participants had clear concepts and a general consensus in relation to its value – even Participant 7 who was most unclear about the present phenomena of Prime worker.
Graph 5.2 Participants working in Safeguarding outside the PCT being studied. Maximum score for each statement could have been 44 (4x11)
5.3.3 Participants working in the PCT and Safeguarding.

These Participants included the Clinical Nurse Specialist and the lead Director for Child Protection. There was a general consensus across the categories 'Responsibilities' and 'Communication'. There were some wide differences in views in relation to who could undertake the role of Prime worker. There were also differences in scoring in the category 'Working Together' – again these differences center around health visitors being attached to GP practice and the impact of constant organisational change.
Graph 5.3 Participants working in Safeguarding and the PCT being studied. Maximum score for statement could have been 22 (2x11)
5.3.4 Participants working closest to Clinical level.

It has been constantly noted throughout the analysis stage that there were remarkable similarities to sittings across all categories for Participant 10 (Clinical Nurse Specialist) and 4 (GP and Clinical Governance Lead for PCT). These two participants were working at a clinical level within the PHCT or closely with practitioners working in the PHCT. Graph 5.4 clearly visualizes this parallelism. Most noticeable are similarities to scoring in 'Communication' & 'Responsibilities' categories. There were some differences in views in relation to 'Roles' & 'Working Together' and these related to the GP strongly disagreeing with Statements 53, 61, 63, 65, 84 and 87. These centre on GPs being perceived as unclear about their role in child protection. This was not an unexpected finding.
Graph 5.4. Scoring of the two participants working closest to clinical level. (Note similar scoring across categories).
Table 5.1 lists the statements of the Q-sort and gives the overall statement scored out of 110 for each statement. It breaks down the participants into those working in the PCT being studied (A) and those working in safeguarding but not in the PCT being studied (B). The maximum overall score could have been 44 in each of these groups. The final column (C) presents the scoring of the two participants working in the PCT and safeguarding. The statements highlighted in red indicate a difference in overall scoring of +/- 9 between groups A+B. This represents a 20% or more difference in scoring between groups.
<table>
<thead>
<tr>
<th>Statements with +/- 9 (20%) difference in overall scoring between two groups A &amp; B</th>
<th>Overall statement score</th>
<th>A PCT Score</th>
<th>B Safeguarding Score</th>
<th>C PCT &amp; Safeguarding</th>
</tr>
</thead>
<tbody>
<tr>
<td>A = Participants 4, 5, 8, 9.</td>
<td>B = Participants 1, 2, 3, 7.</td>
<td>C = Participants 6, 10.</td>
<td>110</td>
<td>44</td>
</tr>
<tr>
<td>1. More effective child protection systems are needed in general practice.</td>
<td>89</td>
<td>29</td>
<td>39</td>
<td>21</td>
</tr>
<tr>
<td>2. GPs often devolve to health visitors the responsibility for decision-making about referrals to social services.</td>
<td>84</td>
<td>27</td>
<td>38</td>
<td>19</td>
</tr>
<tr>
<td>3. Members of the primary health care team will continually encounter children in need of protection.</td>
<td>81</td>
<td>37</td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>4. Practitioners at all levels should be supported in their role of protecting children.</td>
<td>106</td>
<td>42</td>
<td>43</td>
<td>21</td>
</tr>
<tr>
<td>5. It is important that all members of the PHCT are aware of vulnerable children and families.</td>
<td>103</td>
<td>39</td>
<td>43</td>
<td>21</td>
</tr>
<tr>
<td>6. Policy does not necessarily lead to change.</td>
<td>81</td>
<td>34</td>
<td>35</td>
<td>12</td>
</tr>
<tr>
<td>7. A support network for child protection within primary care teams is essential.</td>
<td>95</td>
<td>35</td>
<td>39</td>
<td>21</td>
</tr>
<tr>
<td>8. The role of Prime worker for child protection within primary care has implications on an already high workload.</td>
<td>88</td>
<td>35</td>
<td>37</td>
<td>16</td>
</tr>
<tr>
<td>9. Protecting children cannot be left to the professionals alone.</td>
<td>105</td>
<td>43</td>
<td>41</td>
<td>21</td>
</tr>
<tr>
<td>10. The key child protection professional for each PHCT may need training, protected time and support in order to undertake this role.</td>
<td>100</td>
<td>40</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>11. Each GP Practice must have a lead child protection professional.</td>
<td>93</td>
<td>35</td>
<td>37</td>
<td>21</td>
</tr>
<tr>
<td>12. Achieving high-quality services that help give children the best start in life rests with those who work with children and families on a daily basis.</td>
<td>82</td>
<td>27</td>
<td>34</td>
<td>21</td>
</tr>
<tr>
<td>13. What is needed is for Trusts to commission child protection as a service in which GPs are given the time and money to prioritise it.</td>
<td>62</td>
<td>17</td>
<td>27</td>
<td>18</td>
</tr>
<tr>
<td>14. What is needed is for Trusts to commission child protection as a service that GP's can opt into.</td>
<td>22</td>
<td>10</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>15. All those working in the field of health have a commitment to protect children.</td>
<td>93</td>
<td>39</td>
<td>32</td>
<td>22</td>
</tr>
<tr>
<td>16. Those who occupy senior positions must be required to account for any failure to protect vulnerable children from deliberate harm or exploitation.</td>
<td>98</td>
<td>39</td>
<td>38</td>
<td>21</td>
</tr>
<tr>
<td>17. Health professionals may be the first to detect that a child is at risk, and the consequences of them failing in this recognition can be dire.</td>
<td>95</td>
<td>34</td>
<td>41</td>
<td>20</td>
</tr>
<tr>
<td>18. Understanding the ideas that underpin policy is essential if staff are to appreciate the context in which they work.</td>
<td>96</td>
<td>38</td>
<td>38</td>
<td>20</td>
</tr>
<tr>
<td>19. The key child protection professional for each PHCT needs financial incentive in order to undertake this role.</td>
<td>50</td>
<td>14</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>20. Enhanced roles undertaken by staff should be clearly defined in their job description.</td>
<td>100</td>
<td>37</td>
<td>42</td>
<td>21</td>
</tr>
<tr>
<td>22. It is at the frontline investment and effort must be concentrated in relation to keeping children safe.</td>
<td>83</td>
<td>26</td>
<td>37</td>
<td>20</td>
</tr>
<tr>
<td>23. Child abuse and neglect is one of the most serious health conditions affecting children... it should be looked at as any life threatening illness.</td>
<td>104</td>
<td>42</td>
<td>42</td>
<td>20</td>
</tr>
</tbody>
</table>
24. GPs work arrangements are a world apart from anyone else's. Local primary care trusts commission GPs to carry out specific services and, consequently, GPs run their surgeries like small businesses. & 73 19 33 21 
25. Initiatives need to be supported by 'the organisation' if they are to succeed. & 101 40 40 21 
26. Primary health care teams should identify a key child protection professional within the practice to whom others will refer for information. & 101 43 38 20 
27. If health visitors were separated from primary health care teams this could result in communication breakdown. & 89 36 35 18 
28. Within the PHCT, staff come to the health visitor with their child protection concerns. & 89 36 34 19 
29. The role of Prime worker for child protection is not needed, as communication is already very good in primary care. & 20 8 9 3 
30. Although practice nurses have high levels of interaction with children, they are frequently unaware of vulnerable children. & 76 31 29 16 
31. Systems are in place to alert GPs how many vulnerable children there are in their Practice. & 69 27 26 16 
32. The climate of constant change within the National Health Service has appeared to destabilise local child protection networks. & 71 26 31 14 
33. Communication with other agencies is not a problem in GP Practices. & 27 10 13 4 
34. There is a risk of becoming too 'strategic' and distancing senior staff from the day-to-day realities. & 78 29 33 16 
35. The Prime worker for child protection should be someone the GPs will liaise with. & 101 40 40 21 
36. Regular discussions of vulnerable families within a PHCT can help professionals provide early support to vulnerable families. & 102 38 43 21 
37. There is a risk that during organisational change, children may be less safeguarded than previously. & 87 36 33 18 
38. Communication between staff in the same and different agencies is of paramount importance to ensuring the protection of children. & 106 40 44 22 
39. Legislation alone will not improve communication or increase collaboration. & 100 40 42 18 
40. Effective communication relating to child protection is important at the interface of general practice. & 104 39 44 21 
41. Poor communication has been a significant factor in the historical failure to protect children from abuse and neglect. & 108 42 44 22 
42. There are clearly aspects of the political and social context that work against effective communication and co-operation, such as frequent organisational change. & 86 36 36 14 
43. A supportive network should be established at the 'grass-roots' level where child protection issues and concerns can be identified at the earliest opportunities in a proactive and preventative way. & 99 39 39 21 
44. The role of the Prime worker for child protection is not clearly understood. & 69 28 27 14 
45. The health visitor is the most appropriate person to be the Prime worker for child protection within primary care. & 80 34 27 19 
47. Health Visitors have a high degree of involvement in child protection matters. & 92 39 33 20 
48. The role of the Prime worker should be undertaken through good will and commitment rather than any reward. & 38 18 14 6
<p>| | | | | |</p>
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>49. In GP Practice, child protection is the responsibility of health visitors.</td>
<td>28</td>
<td>11</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>50. Health visitors are seen as the professional group within health that is clearest about its own professional role in protecting children.</td>
<td>89</td>
<td>33</td>
<td>35</td>
<td>21</td>
</tr>
<tr>
<td>51. A child protection lead professional in GP Practice has a role in coordinating training needs of all Practice staff.</td>
<td>94</td>
<td>38</td>
<td>37</td>
<td>21</td>
</tr>
<tr>
<td>52. The role of lead child protection professional in primary health care teams should be continued.</td>
<td>95</td>
<td>38</td>
<td>36</td>
<td>21</td>
</tr>
<tr>
<td>53. GPs are expected to contribute to a process for which they perceive themselves as having little time, experience or appropriate training.</td>
<td>76</td>
<td>24</td>
<td>35</td>
<td>17</td>
</tr>
<tr>
<td>54. The organisation already has enough child protection specialists; therefore the role of Prime worker for child protection within primary care is not required.</td>
<td>27</td>
<td>13</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>55. A child protection lead professional in GP Practice should be a GP.</td>
<td>38</td>
<td>15</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>56. Any member of the PHCT could undertake the role of Prime worker for child protection.</td>
<td>57</td>
<td>20</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>57. The role of Prime worker for child protection within primary care is an informal arrangement whereby one of the health visitors takes on that role.</td>
<td>44</td>
<td>15</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>58. Health visitors have a high degree of interest in child protection matters.</td>
<td>101</td>
<td>41</td>
<td>39</td>
<td>21</td>
</tr>
<tr>
<td>59. Because of the universal nature of health provision, health professionals are often the first to be aware that families are experiencing difficulties in looking after their children.</td>
<td>86</td>
<td>30</td>
<td>35</td>
<td>21</td>
</tr>
<tr>
<td>60. Within the primary care team the person with the most interest in child protection is not necessarily always the health visitor.</td>
<td>73</td>
<td>31</td>
<td>34</td>
<td>8</td>
</tr>
<tr>
<td>61. GPs are the professional group most unclear about the role of others within the child protection process.</td>
<td>68</td>
<td>19</td>
<td>33</td>
<td>16</td>
</tr>
<tr>
<td>62. A more active role for a lead child protection professional is required in GP Practice.</td>
<td>93</td>
<td>34</td>
<td>40</td>
<td>19</td>
</tr>
<tr>
<td>63. GPs are the professional group most unclear about its role in child protection.</td>
<td>69</td>
<td>20</td>
<td>32</td>
<td>17</td>
</tr>
<tr>
<td>64. Health visitors have extensive training in child protection.</td>
<td>86</td>
<td>36</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td>65. GPs are on the periphery of child protection system and uncertain what is expected of them.</td>
<td>73</td>
<td>22</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>66. More time should be given to the role of the lead professional for child protection within GP Practices so that the job can be done properly.</td>
<td>85</td>
<td>31</td>
<td>34</td>
<td>20</td>
</tr>
<tr>
<td>67. The Prime worker for child protection is valued, they are talked about, and their profile is high.</td>
<td>58</td>
<td>18</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>68. The PCT already have child protection specialists, therefore the role of Prime worker for child protection within primary Care is not needed.</td>
<td>28</td>
<td>9</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>69. If you do not have a PHCT working cohesively and working together, then this is where vital information is lost.</td>
<td>102</td>
<td>41</td>
<td>42</td>
<td>19</td>
</tr>
<tr>
<td>70. Meeting regularly enables all the professionals involved with children to have regular and easy communication.</td>
<td>104</td>
<td>38</td>
<td>44</td>
<td>22</td>
</tr>
<tr>
<td>71. It is important that other agencies are aware that there is a lead professional in general practice that they can liaise with about child protection concerns.</td>
<td>102</td>
<td>37</td>
<td>43</td>
<td>22</td>
</tr>
<tr>
<td>72. Health visitors should always be attached to GP Practices.</td>
<td>73</td>
<td>27</td>
<td>30</td>
<td>16</td>
</tr>
<tr>
<td>Statement</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td></td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<td>73. Meeting regularly and sharing information face-to-face there is a much stronger element of trust in relation to discussing child protection concerns.</td>
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<td>74. The health visitor’s role is very much in the PHCT working alongside the GPs and other members of the team.</td>
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<td>75. The cumulative pressures of constant change in the health service have adversely affected the capacity of certain health professionals to take a participatory role in child protection.</td>
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<td>76. Child protection concerns could be missed if health visitors were separated from primary health care teams.</td>
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<td>77. On-going structural change in the NHS is seen as particularly problematic in fracturing the health service.</td>
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<td>16</td>
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<tr>
<td>78. The families at greatest risk are those outside the child protection system.</td>
<td>16</td>
<td>5</td>
<td>9</td>
<td>2</td>
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<td>79. One of the problems for GPs working in child protection is accessing training.</td>
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<td>80. Failure to implement collaborative working has led to the fragmentation of care and can lead to poor outcomes.</td>
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<td>19</td>
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<tr>
<td>81. Actually in my role, we don’t do child protection.</td>
<td>16</td>
<td>5</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>82. Since the introduction of the GMS Contract, GPs are more likely to prioritise other services above those focused on children.</td>
<td>74</td>
<td>29</td>
<td>27</td>
<td>18</td>
</tr>
<tr>
<td>83. Paying GPs to take child protection into account will confirm many of the suspicions that frontline practitioners have about doctors’ attitudes towards child protection ranging from disinterest to out-right obstruction.</td>
<td>78</td>
<td>27</td>
<td>34</td>
<td>17</td>
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<tr>
<td>84. The National Service Framework for Children minimum requirement of every trust appointing a children’s lead will draw GPs out of their silos.</td>
<td>45</td>
<td>9</td>
<td>19</td>
<td>17</td>
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<tr>
<td>85. GPs rely on health visitors to provide information on the social situation of the child / family in order to assess risk.</td>
<td>96</td>
<td>36</td>
<td>39</td>
<td>21</td>
</tr>
<tr>
<td>86. The vehicle the Government chose for encouraging GPs to work more closely with children’s services is the National service Framework for Children, Young People and Maternity Services.</td>
<td>70</td>
<td>27</td>
<td>28</td>
<td>15</td>
</tr>
<tr>
<td>87. Ask most children’s professionals what they really think of GPs and child protection and they’ll describe a ‘reluctant partner’.</td>
<td>75</td>
<td>23</td>
<td>34</td>
<td>18</td>
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</table>

Table 5.1. Statements in the Q-sort identifying differences in scoring between those working in the PCT (A), those working in safeguarding but not in the PCT being studied (B) and those working in both the PCT and safeguarding (C). (NB 21A and 46R removed 26.11.2005 as repetitive).

Statements with +/- 9 (20%) difference in overall scoring between two groups A & B.

**A = Participants 4, 5, 8, 9.**  
**B = Participants 1, 2, 3, 7.**  
**C = Participants 6, 10.**

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5.4 Top and bottom scoring statements.

There were no wide discrepancies in the top and bottom scoring statements for either group. Those who worked in 'safeguarding' not in the PCT (Group B), gave maximum overall score 'most agree' (44/44) to four statements – 38, 40, 41 and 70. All these statements relate to the importance of effective communication. The statements with the lowest overall score 'least agree' (9/44) were – 14, 29, 81. These statements confirmed strong views that GPs should not be allowed to ‘opt into’ child protection that it was ‘everyone’s responsibility’ and the Prime worker was needed because communication was not good in primary care with other agencies:

There may be huge difficulties but it does not mean people are not communicating ... but I think that communication with meaning and understanding is probably a HUGELY* different experience. (R3)

GP s opting into anything with regard to child protection issues is worrying ... clearly communication is a problem ... (R2)

...communication is a problem ... in the broader safeguarding agenda ... it is a problem'. (R1)

Those working in the PCT (Group A), the highest overall score for any statement was 43/44 – statements 9 and 26. These refer to child protection being everyone’s responsibility and not just the professionals, and each PHCT should identify a lead child protection professional. The statements with the lowest score ‘least agree’ – 81 (5/22), 29 (8/22) and 68, 84 (9/22). These again refer to ‘everyone’s responsibility’ that the role of Prime worker is needed in the PHCT and those in the PCT highlighted a stronger view that the Prime worker did not replace the child protection specialist’s role. Those working in the PCT also expressed stronger views the NSF would not draw GPs ‘out of their silos’:

I sometimes wonder if GPs are aware what NSF’s are out there and I honestly believe unless you link it to how they are remunerated ... then it becomes very real for them. (R6)

* Denotes participant voice emphasis.
Would like to think the NSF would change the world ... whether this would change GPs views ... I'm not sure. (R7)

Those working in safeguarding and the PCT being studied (n=2) scored 20-22/24 on 35 of 85 statements. This is not an unexpected finding amongst those working in the child protection in PCT being studied as these were the people driving the safeguarding agenda. They gave maximum statement scores to 8 statements – 15, 38, 41, 70, 71, 73, 74 and 80. These relate to ‘everyone’s responsibility’, the role of the health visitor in PHCT and six statements relating to the importance of effective communication networks, systems and the impact on outcomes for children of poor communication. The statements with the lowest score ‘least agree with’ are 81 (2/22), 14, 29, 54 and 68 (3/22). Again, these statements refer to ‘everyone’s responsibility’, GPs not being allowed to ‘opt out’ of child protection and three statements relating to the value of the Prime worker. There was consensus across statement 14 and 81 in all participants and groups, as already discussed in the previous chapter.

5.5 Statements with least congruent scoring between groups.

In this section, scoring between groups A & B will be discussed where there is a difference of +/- 9 (20%) in overall scoring. There were 17 statements with a diverse scoring.

<table>
<thead>
<tr>
<th>Category</th>
<th>Least congruent statements</th>
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<tbody>
<tr>
<td>Responsibilities</td>
<td>n= 7/24 (1,2,3,13,19,22,24)</td>
</tr>
<tr>
<td>Communication</td>
<td>n= 0/18</td>
</tr>
<tr>
<td>Roles</td>
<td>n= 5/24 (53,56,61,63,65)</td>
</tr>
<tr>
<td>Working Together</td>
<td>n= 5/19 (75,76,78,84,87)</td>
</tr>
</tbody>
</table>

It was interesting to note there were no wide variations between the scoring of the two groups in the ‘communication’ category (statements 26-43). This consensus is also matched with the participants in group C.
The diverse scoring statements have been incorporated into three emerging themes:

- The role of the GP in Safeguarding.
- The role of the Prime Worker.
- Managing Change.

5.5.1 Role of the GP in Safeguarding.

It was also interesting to note 8/16 of these statements with diverse scoring, were related to GPs and respondent’s perceptions of GPs role in safeguarding children (statements 2, 13, 24, 53, 61, 63, 65, 87). Those working in safeguarding but not in the PCT (group B) had stronger views of the statement GPs did often devolve responsibilities for child protection referrals to health visitors:

...GPs only too often will devolve the responsibility. (R7)

This links to the findings of the studies undertaken by Bannon et al. (2001, 2003b), Burton (1996) and Lupton et al. (1999). Those working in both the PCT and Safeguarding also had strong agreement with the statement but noted:

I agree ... but times are changing ... some of them are beginning to take on that responsibility themselves ... but I do think they often devolve decision making (R10).

Statement 13 and 24 relate to commissioning child protection arrangements. Those working in the PCT had stronger views on the PCT should not specifically commission child protection ‘in which GPs are given the time and money’:

...its more about time and less about money ... many of us in executive roles find this ...GPs will only do something if you give them money ... no other service behaves like that. (R4)

I’m not sure what the most effective way of getting GPs involved ... I’m certainly not convinced it’s money. (R5)
My main disagreement ... give the money to GPs to prioritise it ... its part of their contract to provide care to their patients. (R4)

Several participants commented there was 'not being very much for children' (R4) in the GMS Contract or they presumed there was (R5) and commented on the 'Quality Outcomes Framework' (QOF):

*If there was a QOF related to Children's Services, then GPs would do more because that's the way they behave. (R4)*

Participant 1 was lead PCT Director for Child Protection in the county being studied. She was the only respondent to put GPs responsibilities into the context of legislation:

*At the end of the day it is systems put into place that allow children to be protected ... their work arrangements are irrelevant ... they must comply with legislation.*

Those working outside the PCT had stronger views in relation to the role in statements 53, 61, 63, 65 and 87. They were more likely to still perceive GPs as having little time, experience, training and understanding of their role and be 'reluctant partners'. Again, this reflects the findings of Bannon *et al* (2001, 2003), Burton (1996), and Lupton *et al* (1999).

However, PCT participants had more positive views:

*It is probably true of some GPs but very untrue of others. (R8)*

*Accessing training ... could be a problem in some areas although in this area we try to address it. (R5)*

*I think that is untrue (GPs being unclear about their role)... there may be instances where generally they see themselves as being the lead. (R4)*

Compared to those working in child protection and in the PCT, comments were varied:

*I've put the health visitor being the most appropriate ... purely because of gaps in knowledge of the GPs ... but hopefully we are starting to address that through Enspiral. (R6)*
GPs are on the periphery because they have been allowed to be ... and yes they are uncertain of what is expected of them in child protection ... they are often quite anxious, frightened and wary ... the amount of training they uptake remains patchy and varied ... some are very good and learn as much as possible and get confident ... others just don't want to know. (R10)

5.5.2 The Prime Worker role.

Although statement 1 had a high agreement scoring, it was interesting those working in child protection (group B & C) had a stronger agreement that more effective systems were needed in general practice and members of the PHCT would continually encounter children in need of protection (statement 3). This is important to note as these people were working in a multi-agency environment trying to work together to safeguard children in the county being studied. This link also applies to the diverse sitings of statement 22 – 'It is at the frontline that investment and effort must be concentrated in relation to keeping children safe!'

More effective systems are needed ... it is around receptionist ... practice nurses and other key staff who probably have more contact with families. (R7 group B)

I might slightly disagree ... child protection is pretty good around here but I suppose you could always say it should be better. (R4 group A)

There was consensus in both group A & C over statement 56, where those working in the PCT had stronger views who should undertake the role of Prime worker. These participants had worked with the role for eight years. There was also a more consistent scoring response over the three similar statements included in the sort to test this idea and draw out participants views of who should undertake the role (statements 45,55,56). It was intriguing to note there was consensus in groups A & B in disagreeing GPs should undertake the role:

I put the health visitor as most appropriate ... that I most agree with ... but I think there are circumstances where other members of the team could take it. (R5)
Any member ... I don’t think that is true ... you need the right person ... I have put it does not have to be a health visitor ... there may be instances where it could be a GP with special interests ... I don’t think it could be a receptionist. (R4)

These last comments refer to recent 'considerations' to GPs with Special Interests (GPwSI) (DH 2003a).

Statement 78 with an overall statement score of 69 was not a statement with particularly strong views, but there was a notable difference in scoring between group A & B, with those working outside the PCT disagreeing more than those working in the PCT being studied ‘The families at greatest risk are those outside the child protection system’.

There is a link here to the DH (2004e) publication for primary care relating to the NSF for Children, Young People and Maternity Services, that highlights the number of times a child is likely to be seen by a GP or other member of the PHCT in one year. Participant 10 reinforces this:

Yes, the families at greatest risk are those who haven’t yet gone into the child protection system and that’s where the Prime worker is ... and constantly highlighting them to the PHCT. (R10)

For statement 19, those working in the PCT had stronger views disagreeing the Prime worker needed financial incentives. The comments made around this statement were interesting:

I found that an interesting one for myself ... my value base ... because I thought it important ... but I think they do need to have financial ... that is why I have moved it to +5. (R3)

I’m SURE IT IS NOT* ... there are values more important in this ... if you can just catch hold of them and understand ... more than money ... the contracting mechanism used. (R5)

I don’t think financial incentivisation is necessary ... RIGHT * person doing the right role ... if you have to incentivise ... then it is the wrong person. (R8)

* Denotes participant voice emphasis.
Again, those in group B & C had similar scoring and comments:

*I disagree with people needing financial incentives ... and then balance that with being clearly defined in peoples job descriptions and that includes giving people the time to do it. (R6)*

*... this is debatable ... yes ... you know they should in an ideal society ... still ... they will do it if they are rewarded in other ways ... making them feel special and valued ... goes a long way ... making it an important role does help in the absence of financial remuneration. (R10)*

5.5.3 Managing Change.

Statement 75 stated *The cumulative pressures of constant change in the health service adversely affected the capacity of certain health professionals to take a participatory role in child protection*: Those working in the PCT agreed more to this statement than those outside the PCT. It was interesting to note a consensual high scoring agreement to a similar statement - 27:

*I think it has got too great at the moment ... the rate of change ... reform ... reform ... reform is too much I'm afraid. (R4)*

*I think that is absolutely true ... I would like to have pushed it across (points towards +5) ... but some parts of the system like the GPs don't ... FEEL change so much because it isn't their organisation being changed all the time ... but for others it is reducing their capacity... enthusiasm to take things onboard. (R5)*

There were several statements within the Sort relating to health visitors, which sought views as to whether being based away from the PHCT could impact on child protection within the PHCT (27,72,74,76). Again, these statements were included to compare scoring and draw out strongly held views from participants. Those working in the PCT being studied had stronger views that child protection concerns could be missed if health visitors were separated. There was a stronger consensus that health visitors had an important role in working alongside GPs and PHCT, and communication could break down if health visitors were separated. It was a surprise to the researcher the low

* Denotes participant voice emphasis.
scoring for statement 27 in relation to health visitors 'should always be attached'. However, the comments made around this statement were enlightening:

*Denotes participant voice emphasis

There is talk about health visitors being separated from PHCTs'... could result in poor communication... I'm SURE THAT'S TRUE*... it has already happened with the district nurses... it's been awful... I strongly support health visitors being attached. (R4)

I think you CAN *get good linkages if people are managed on locality-type arrangements... I don't disagree they should be attached but I don't think they HAVE *to be. (R5)

It could result in communication breakdown especially as personal communication makes such a difference to what they pass on... yes I do think health visitors should ALWAYS* be attached... in some way definitely... even if they are not working physically in the same practice... they would have to have a named health visitor... yes ABSOLUTELY* the health visitors role is very much in the PHCT alongside the GPs. (R10)

Statement 84 related to the Children's NSF. Those working outside the PCT being studied held stronger views on the requirement of the NSF to appoint a children's lead would draw GPs out of their silos. However, those working in the PCT scored significantly lower in disagreeing with the statement.

I don't think the NSF is drawing GPs out of their silos (laughs)... I really don't. (R5)

It will take more than that to draw GPs out of their silos... GPs don't live in silos really... they live in their own little world (laughs). (R8)

5.6 Summary on the Sort and Post Sort discourse by Participant.

5.6.1 Participant 1

Participant 1 was lead PCT Director for child protection in the County being studied. She held strong views GPs were running a small business, however it should not be a consideration in respect of child protection. She was the only
respondent to make clear links to statutory obligations to comply with the legislation of the Children Act 2004. She acknowledged the difficulties for GPs where they are:

*Working with a magnitude of different issues ... it is very difficult for them to embrace the safeguarding agenda ... it is right they focus on the serious child protection element ... but that in itself makes their role unclear.*

She was unfamiliar with the concept of Prime worker but stated how poor communication was a recurrent theme in Serious Case Reviews and there was still a lot to learn. In respect of health visitors being separated from the PHCT, she commented it was more important to establish good working relationships with effective policy and procedures in place, then *it wouldn't matter where they were based*. Participant 1 emphasized the role of Prime worker should be formalised and incorporated into job descriptions and acknowledged it should be taken into consideration in re-configuration.

She summarized post sort that in the wider safeguarding agenda, there was a very important role for a Prime worker and acknowledged it was no longer present in any form in the PCT where she was working and should be reviewed.

5.6.2 Participant 2.

Participant 2 was a senior member of staff working in social services. He was initially anxious about his knowledge of GP practices. He held very strong views around communication within GP practices and *clearly it is a problem for other agencies*. Throughout the sorting process, he kept referring back to:

*The most frustrating thing is communication ... I can't say enough about communication.*

In his own agency, he was familiar with the development of the 'lead professional role' to support multi-agency working and viewed it as:
HUGELY IMPORTANT* and has got to be helpful for communication.

He was surprised to have worked for eight years in the county and was not aware of the role in GP practices. He considered most importantly the Prime worker should be:

Someone who is accessible ... there regularly ... easy to contact ... able to disseminate information ... be available to liaise with other agencies.

He expressed concern about health visitors, because of the decreasing amount of contact with families, huge caseloads and they may now not *necessarily be the ones to pick up concerns*. He considered the practice manager might be more appropriate. In relation to the NSF, he did not feel it would make any difference to how GPs are perceived to engage in child protection:

I’m not convinced anything would get GPs out of their silos ... paying them?

He made constant references to multi-agency working:

It’s the government agenda ... we have all got to do it.

5.6.3 Participant 3

Participant 3 was senior Child Protection Advisor within social services. As already described, she expressed strong views in respect of how staff should be financially ‘rewarded’ for taking on enhanced roles. She presumed the key child protection professional for each PHCT for pragmatic reasons would be a nurse. She did not hold strong views health visitors should be attached to GP practice but acknowledged:

Health visitors are currently likely to be the people both who can helpfully contribute to child protection and are best used in practices.

* Denotes participant voice emphasis.
She made constant references to communication with emphasis on the importance of 'Effective communication ... communication with meaning and understanding'; and made several references to findings and recommendations of the Laming Report 2003. Participant 3 had varied views about GPs role in child protection and highlighted there were some GPs extremely interested in child protection – as there were health visitors and vice versa. In relation to the NSF, she did not agree it would 'draw GPs out of their silos'. She was not familiar with the role of Prime worker as it existed but stated:

Certainly I can see a role for a Prime worker ... but they do need to be supported.

5.6.4 Participant 4

Participant 4 was a GP and Clinical Governance lead in the PCT being studied. He commented and questioned how little he knew about the GMS Contract within which he was working ... the Trust commissioning child protection ... giving money to GPs to prioritise child protection ... doing it as part of their contract to provide care to their patients ... 'I assume they do' (laughs). As the only person in the study working directly with the GMS Contract, he acknowledged GPs were more likely to prioritise other services (82W):

I think that is true actually at the moment as there isn't very much on children ... if there was a Quality Outcomes Framework related to children's services then GPs would do more.

He acknowledged the Prime worker could not be any member of the PHCT but also it did not have to be a health visitor. He considered it could be a GP with Special Interests (GPwSI). He also acknowledged whilst there were child protection specialists in the PCT to whom staff could refer that 'you still need it at the coalface'. He challenged some of the statements about GPs being unclear about their role and being 'reluctant partners', but conceded this is how they may be perceived.
Participant 4 was familiar with the Prime worker role and had worked with it since 1997 at first inception. His personnel views were that more effective child protection was not needed, as 'child protection is pretty good around here'. He stressed the value and importance of weekly PHCT meetings where child protection had a dedicated slot but emphasized this may not be true across all GP practices:

_I don't think most GPs know what the word Prime worker in child protection means._

Strong emphasis was placed on importance of communication and he gave credence to the role of Prime worker 'communication is as good as it can be'. He acknowledged where there were electronic systems in place to alert GPs to children who were subject to a Child Protection Plan, apart from the Prime worker, there was 'no such system to alert GPs to other vulnerable children'. He held strong convictions that if health visitors were separated from the PHCT it would result in communication breakdown. He made reference to the impact it recently had when district nurses were separated.

5.6.5 Participant 5

Participant 5 was the most senior person in the PCT being studied. As highlighted previously, she concentrated her comments around the statements she was most unsure about. She stated she was not sure what was the most effective way of getting GPs more closely involved in child protection and giving it a higher priority, but she was 'SURE it was not money'. Like Respondent 10, she focused on values:

_I think there are values that are more important in this ... but I'm really quite uncertain how to get hold of their attention (GPs)._  

She made comments about accountability (16A):

_I feel I ought to put it in '5' because people should be held to account ... but I hesitated and put it at '4' ... because I'm not always sure the links we have mean the people at the top have all the tools available to be absolutely accountable._
She emphasized that child protection was everyone's responsibility but:

*They can't do it without Policy ... Policy ... organisational support and training ... protected time is needed ... all of it is needed in the mix.*

In respect of the impact of health visitors being separated from the PHCT, she expressed strong views:

*...you CAN * get strong linkages if people are managed in a locality -type arrangement and I believe we ought to put things in place to counter it.*

She constantly reiterated the Prime worker role was needed but in some Practices it was working well and not so in others, and the role may not be clearly understood. She emphasized the importance of it being someone the GP could liaise with:

*I strongly disagree the role is not needed ... but I don't think we have cracked it ... I have a recollection of the survey that came to Board about what is being done in individual Practices and some were right up there and some ... weren't there at all ... and they had the same input and leadership on what should be happening around child protection.*

Participant 5 highlighted the health visitor as being a key health professional in respect of child protection in primary care and viewed them as the most appropriate person to undertake the Prime worker role, but also considered a GP. She viewed the role as an important *'core part of the job rather than an add-on to the health visitor role'.* She commented she did not know if GPs had difficulty accessing training. She held strong convictions in respect of communication:

*... IS a real issue ... I've pushed it RIGHT UP HERE * (points to +5) ... I'm a strong believer in face-to-face ... trust is an important element ... if a team is not working cohesively there is a danger.*

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* Denotes participant voice emphasis.
As the most senior member in the PCT being studied, the researcher was interested to note her comments around the impact of constant organisational change (32C):

\[\text{The climate of constant change ... I'm thinking VERY\textsuperscript{*} local here ... this PCT ... I DON'T THINK\textsuperscript{*} that has happened ... it might be happening in other PCTs.}\]

In relation to (75W) 'The cumulative pressures of constant change ... have adversely affected the capacity of certain health professionals to take a participatory role in child protection'; her comments have already been quoted in section 5.5.3.

5.6.6 Participant 6

Participant 6 was the lead Child Protection Director in the PCT being studied. She commented:

\[\text{We need to keep (child protection) in the Quality Outcome Framework in which we Commission services.}\]

She did not believe the NSF for Children would be the vehicle for GPs to become more actively involved in Childrens Services.

\[\text{I honestly believe unless you link it to how they are remunerated then it becomes very real for them.}\]

Her comments around the statements around GPs involvement in child protection and they could often be viewed as 'reluctant partners' were interesting. She stated they may often appear reluctant because of their lack of knowledge and lack of experience:

\[\text{... if you start to work with them ... flag up the issues and give them confidence in terms of what they are dealing with it becomes easier.}\]

\* Denotes participant voice emphasis
She held strong views against financial incentives and believed the role of Prime worker should be incorporated into job descriptions. She had strong views in relation to communication, that enabling a network of communication in the PHCT:

*Is really important ... I REALLY DO THINK* primary care aren't necessarily very good at communicating ... they are very much individual practices ... and sometimes not even good communicators WITHIN *practices ... that is an issue we need to work with around protecting children.*

She placed emphasis on the importance of working together ... the impact of failure to implement collaborative working throughout the PHCT and not developing supportive networks where *trust can be developed in discussing child protection concerns*. In respect of health visitors being attached to GP Practice, she held strong views:

*If communication is going on then people do not necessarily need to be attached ... as long as there is networking and people are clear about roles and responsibilities.*

Again, the researcher was interested in her views around the impact of constant organisational change. She stated *'I'm in two minds ... but I think sometimes it can be an excuse'*. She put strong emphasis on the importance of strong leadership and policies being in place:

*There has got to be the systems and someone with an overview ... helicopter view ... to step back and see what is happening.*

She had strongly held views around the Prime worker role:

*I think it is absolutely KEY* within primary care ... it would be wonderful if in some cases it could be a GP ... but at the moment it is falling to the health visitors*

* Denotes participant voice emphasis.
She acknowledged the Prime worker profile should be raised within primary care and recognised some PHCTs would embrace the role with enthusiasm, others may not and emphasized the importance of support networks for Prime workers in order they did not feel isolated or demoralized. She diverted discussion away from the Prime worker to the wider safeguarding agenda – to other agencies who may have more contact with children and a role in safeguarding than health.

5.6.7 Participant 7

Participant 7 was the Strategic Health Authority lead for Safeguarding and was not familiar with the concept of Prime worker. She commented more effective systems were needed in PHCT and ‘I can see a need for coordinating and training within primary care’, but really struggled with the notion of Prime worker – reflecting several times it was ‘individual professional responsibilities’.

She held strong views in respect of not paying GPs to safeguard children and on financial incentives for enhanced roles. She was quite clear it was ‘everybody’s responsibility’. She held strong convictions around organisational change and it should not be blamed for ‘breakdown in systems’. She highlighted the importance of effective communication:

\[ \textit{Communication is key} \ldots \textit{every single review focuses on communication} \ldots \textit{and communication doesn’t harm anyone it protects vulnerable adults and children} \ldots \textit{sharing information is KEY*}. \]

She emphasized the importance of PHCT meetings and discussions led around child protection issues. Although struggling with the idea of the Prime worker, her final comments add great weight to the outcomes of this study:

\[ \ldots \textit{if it keeps child protection alive within primary care}. \]

*Denotes participant voice emphasis.
5.6.8 Participant 8

Participant 8 was a Director in the PCT being studied. Her discourse was initially mostly around questioning statements and their subjectiveness. She repeated the statements as she sorted commenting only 'this is true ... not true'. She disagreed with the statements 'at the frontline investment and effort must be concentrated' (22A), emphasizing it was needed at all levels and not just at the frontline. She held strong views against financial incentivisation:

In today’s world ... it is about job planning and organisation... and the RIGHT* person to do the right role.

She stated it was good management practice that enhanced roles should be clarified within job descriptions. She held strong views each GP practice should have a lead child protection professional:

I think it is so integral to the role of someone in the practice but it needs to be recognised ... It should be formalised ... and objectives set ... It's about how the PHCT is effectively managed to do the job it needs to do ... child protection is a very important component of the totality of the role of the PHCT.

She was open in respect of who should undertake the role stating in a small Practice or where there is a very committed GP 'we don't rule that out'. She stated she would like to think the Prime worker was valued, talked about, had a high profile but:

... it is obviously more in some Practices than others.

In relation to the Children’s NSF her comments were interesting:

You could argue it is an NHS document and GPs are outside the NHS ... It's very hard to get GPs to actually sign up to that kind of national strategy document at the moment.

Like all participants, she held strong views in relation to the importance of communication and the impact of poor communication systems and networks.

*Denotes participant voice emphasis.
5.6.9 Participant 9

Participant 9 was the only person who did not make any comments during the sorting process although he gave consent to record the meeting. He was invited to make any comments post sort in relation to the research question 'How should children be safeguarded in primary care in relation to child protection'. His only comments were:

*There needs to be a strong central lead ... you can't rely on other agencies ... there needs to be someone to pull it all together ... they have to work together (PCTs and GPs) ... no doubt about that.*

5.6.10 Participant 10

Participant 10 was the Nurse Specialist Child Protection in the PCT being studied and had worked with the role of Prime worker since inception in 1997:

*I totally agree a supportive network be established at grass-roots level and it ABSOLUTELY DEFINITELY* should be continued.

In respect of the GPs role in child protection:

*If GPs are perceived as being on the periphery of child protection it is because we have allowed them to be.*

She said although she acknowledged times were changing 'training remained patchy and varied'.

She emphasized the importance of the organisation valuing and supporting the role. She saw a key role for herself in 'making them feel valued ... goes a long way'. She acknowledged the importance of developing a culture and climate that supports policy and that is what the Prime worker role was trying to achieve, particularly in relation to communication and collaboration. She elaborated communication was not good and that was why the role was

* Denotes participant voice emphasis.
introduced in 1997 and reinforced it was research that showed it was required. She acknowledged communication with other agencies was 'an ENORMOUS * problem' in GP practices and included the failure to understand other professional roles.

Participant 10 held strong views that if health visitors were separated from the PHCT it would result in communication breakdown:

*Personal communication makes such a difference ... and trusting somebody.*

She held strong convictions health visitors remained the most appropriate person to undertake the role of Prime worker as they were working with child protection issues all the time. In respect of the impact of constant organisational change children would be less safeguarded, she believed the Prime worker in the PHCT would:

*Safeguard that from happening ... the Prime worker knows what is happening at all levels and they can inform the managers ... we should be informed by them (the Prime workers) ... just as them being informed by our policies and procedures.*

She believed the Prime worker was valued but the role not clearly understood by people across and outside the organisation, particularly since the other four PCTs in the County no longer actively acknowledged the role. Her comments were interesting around 'the PHCT should identify a key health professional' (26C). She highlighted the fact it was not an informal arrangement and the PCT identifies the Prime worker and puts the systems in place for GP practices:

*One wonders that if given the initiative ... whether they would do it themselves ... we have got a service that the Trust sees as essential and we have put it in place for GPs ... through Prime workers undertaking this role GPs will learn how valuable that actually is.*

She acknowledged the role of Prime worker was:

*Not quite right yet ... there is still a lot of work to be done ... we have done a lot but we can still achieve more.*

*Denotes participant voice emphasis*
She reinforced her belief that the families at greatest risk are the ones that haven't yet gone into the child protection system:

... and that is where the Prime worker is ... Prime workers make a difference to children.

5.7 Interviews

Two interviews were undertaken to explore and challenge different aspects of the findings. They are presented as an interpretation of the interview, however full transcripts are available. Each was asked different questions relevant to the specific aspect of inquiry. Due to the high profile of these participants and importance of maintaining anonymity, the transcripts were peer reviewed to validate that the researcher had included in the interpretation positive and negative comments relevant to this study.

5.7.1 Interview 1 – Director of Primary Care and Public Involvement.

The aim of this interview was:

- To discuss the GMS Contract, GP Commissioning in relation to child protection and where it fits.
- To discuss the Quality Outcomes Framework in relation to Child Protection.
- To review certain statements relating to the above and include the discourse from the sorts (statements 1A, 13A, 14A, 23A, 24A, 31C, 65R, 68R, 82W, 86W).

This interview provided a crucial moment in the study allowing the researcher to reflect on one aspect of the emerging data contributing to 'new knowledge'.

The interview gave clarification in respect of the GMS Contract in that GPs were paid for providing certain core and enhanced services across the population. In respect of child protection, she was puzzled with what appeared to be confusion and misunderstanding as 'child protection was bound by legislation' and should not be viewed as 'a service provided'. She believed the imminent introduction of Practice Based Commissioning would not impact on child
protection issues as 'It only relates to Secondary Care'. In relation to the Quality Outcomes Framework (QOF), she agreed there was very little in respect of children and this may have contributed to people's views around how GPs engage in child protection. She commented that the PCT had little influence over the current QOF but she had been asked to be part of a team reviewing the Contract for 2007. She also posited that the QOF only required GP practices to have access to procedures and this should be reviewed to include requirements of other key policy documents i.e. Working Together (HM Government 2006) and that child protection in respect of monitoring training should be included. However, she also commented that the QOF was voluntary and if a practice did not meet a standard or stated that 'it wasn't worth the £250 you were going to give me', there was very little the PCT could do:

It IS* a small business ... we commission them to carry out specific services ... part of a nationally agreed contract ... but it would be difficult to do anything outside that.

Her comments were interesting in relation to paying GPs specifically to take on an enhanced role in child protection:

If you were coming to me ... I would say ... what is the evidence GPs are going to make a difference here?

She acknowledged GPs were on the periphery and uncertain of what is expected of them, but there had also been noticeable changes in moving towards more active engagement. She reinforced the difficulties for GPs:

There is constantly new ways of doing things ... guidelines for this ... for that ... along with the QOF which requires them to jump through hoops in order to boost their income ... they are small businesses ... but they want to do their best for people ... children included.

She was asked to remark on the Royal College of GPs (RCGP) work on the GP with Special Interests (GPwSI) and if the PCT was promoting this. She was

* Denotes participant voice emphasis.
aware of this but the PCT had no plans to consider GPwSI for child protection, as 'no one as highlighted there is a need'.

She was asked to comment on the research question for this study 'How should staff be supported in primary care in relation to safeguarding children'. She was aware of the Prime worker role and of audits undertaken in 2005. She reiterated the value of the role at PHCT level:

_Its about giving some focus ... some expertise ... providing that place for guidance and support ... keeping it alive in practice ... absolutely ... it has got to be the way forward._

She stressed that in order for this to work in the future especially if health visitors were increasingly based away from the PHCT, 'it also has to be about establishing and maintaining relationships'.

**Note**

Following the interview, the researcher reflected on the findings so far: the audits undertaken, generation of statements, sorting of statements and generation of discourse and considered why child protection within the PHCT was being perceived as 'being put aside' and GPs believed to be only interested in financial reward. The researcher questioned whether the legal requirements (Section 11 Children Act 2004) and policy guidance of Working Together 2006 had been subsumed to the changes and pressures of the political drivers of the NHS. If GPs are perceived as only being interested in financial reward, this could become a block to effective working together. It may not be a reality but how colleagues within and outside health perceive GPs. This led to the request for the second interview.
5.7.2 Interview 2 – Safeguarding Advisor in the Policy Directorate of a key Governmental Department.

The aims for this interview were:

- To review certain statements and discourse from the Q-sorts and to provoke discussion in relation to:
  - How GPs are perceived in respect of their role in child protection.
  - The impact of the changes and Government drivers for primary care.
  - Communication.
  - The impact of organisational and structural change on child protection networks.

- To exchange views of the phenomena being studied with a senior member of the Government Policy Directorate.

She acknowledged it was the existing external perceptions of 'GPs will only do something if you give them money', that gets reflected back to the Department and this was not a surprise (statements 1A, 62R, 63R, 65R, 79W, 87W). She identified there were still real practice issues in getting GPs to undertake training and attending or providing reports for child protection conferences. She was aware of current work being undertaken by the Royal College of General Practitioners (RCGP) in relation to a pack to support GPs in safeguarding, and promoted this work as 'I hope gradually things will improve'.

She was unclear how Practice Based Commissioning would engage GPs in safeguarding, but identified the whole issue of getting GPs to engage in the Children's Agenda:

> It's not just safeguarding ... there is a whole trick to pull off about how you engage them in Children's Trusts and ... what they do in terms of commissioning how it is going to fit into joint commissioning for Children's Trust arrangements.

She identified the difficulties as GPs were running a small business and whereas some GPs may be very interested and engage 'they don't speak for the rest'. She raised questions about how GP practices are set-up, what 'ground rules' were set and whether the Prime worker role should be
embedded in the system and GPs obliged to embrace what is put in place by
the PCT.

In relation to the Quality Outcomes Framework (QOF) - 'If there was a QOF
related to children's services then GPs would do more'; and she highlighted the
difficulties for the Government Policy Team where there was internal
competing in respect of differing policy agendas:

We as a Policy Team try to put in a number of things for children but there is
the process where they don't ever get in.

She was questioned as to whether the QOF was to be reviewed to include
more on children's services:

My understanding this year is because it all cost so much last year ... there is
not going to be a huge change ... but we have tried to put something in ... that
they gave a report for child protection conference ... went through the process
acknowledging they had been invited and writing a report ... but it hasn't got in
... no.

She also identified other difficulties with the QOF and Performance Indicators:

You put something new in ... you have to take something out ... it's REALLY
DIFFICULT*.

In respect of the emerging evidence, Government drivers, targets, contracts,
commissioning etc., may seem to be distracting from responsibilities in relation
to the Children Act's 1989, 2004 (6A, 82W, 86W), but she was clear the QOF
was over and above their basic requirements and child protection was a basic
requirement. In relation to legislation, she reinforced this:

We are trying to operationalize the law here aren't we ... and trying to put
something in place?

She was questioned as to who was monitoring these requirements:

The PCT I suppose ... I can't tell you I'm afraid ... I don't know ... have the
PCTs got a lid on what they are doing?

* Denotes participant voice emphasis.
She discussed not being aware of a process for checking if the PCTs do monitor child protection systems with primary care and identified:

*The new big focus on commissioning ... it is the opportunity to spell out from a PCT perspective ... what the PCT expectations are ... then it is down to them to monitor whether it is delivered.*

She acknowledged emerging evidence that at present, due to vast demands on target driven agendas, there was stronger emphasis on working towards what was being monitored. She questioned whether through Core Standard 2, the Healthcare Commission could require PCTs to evidence they had safeguarding in their commissioning.

In relation to the statements and discussions surrounding ‘Communication’ (29C, 33C, 39C), she questioned whether the researcher had spoken to GPs to gain their perspective on the emerging findings. The researcher informed her that this was being considered through an on-line discussion group of the Royal College of GPs.

She was not surprised with the statements and discourse around the impact of organisational change on safeguarding children (32C, 37C, 42C, 75W, 77W), but stated there was less change for PHCTs than there was for other health service organisations.

The researcher asked her to comment on the main research question ‘How should staff be supported in primary care in relation to safeguarding children?’ She commented on the need for training and more localized PHCT training ‘building a whole team responsibility ... more effective’. She supported the GP with Special Interest Programme (GPwSI) and the role a GPwSI would have in development of Childrens Services and Childrens Trust arrangements, but acknowledged the difficulty again of one GP not representing them all.
She advocated the idea of someone in the practice coordinating child protection and identified the existing Prime worker role. "It seems to be a very good model," questioning who would undertake the role in the future:

*Given the change in health visiting ... how many health visitors are GP attached ... that's an argument for not taking health visitors out of GP practice isn't it?*

She stated she had considered a practice nurse undertaking the role but:

*... the amount of experience they get would not be sufficient ... whereas being a health visitor ... it's much more part of what they do.*

However, she considered more expertise may build up in the practice if the role was given to another member of the PHCT - "someone closer almost to the Practice than perhaps the health visitor has it's merits", but also acknowledged 'we are back to money ... paid to undertake the role'.

She was interested to inquire about the existing Prime worker role and whether it was embedded in the job description. She was informed of the existing protocol and standards in place and annual audit of standards:

*It looks like a good model ... gives you the evidence ... gives you a way-in regarding the safeguarding agenda ... keeping it alive in the PHCT ... yes ... yes that's the trick ... keeping communication channels open.*

She acknowledged the Prime worker role sits in the wider safeguarding agenda and should support the GP Practice in the introduction of the Common Assessment Framework (CAF):

*It seems a really good model ... it is something we are constantly struggling with ... constant allegations back to the department about health not engaging with the Children Agenda ... GPs don't ... and all of that.*

Following the interview, the researcher was asked how the department would receive feedback on this study and she expressed a wish to have a
comprehensive report once the study was completed in order that it could be considered in ‘influencing future policy’.

5.8 GP Email Discussion Group.

The aim of the on-line discussion group through the Royal College of General Practitioners (RCGP) was:

- To gain a wider perspective from GPs in relation to the main research question.
- To provoke discussion around the emerging findings of the study.
- To elicit models of child protection support other PHCTs were using in the UK.
- To explore some of the issues identified as important to this study in the literature review.

The discussion group took place October to November 2006. The group of GPwSI in child protection was already in existence and the ex- Safeguarding Lead of the RCGP facilitated access to the group as discussed in the Methods Chapter.

It is acknowledged these were GPs who already had a specific interest and were mainly the Named GPs for child protection and likely to be the lead in their local PCT. However, they were key to identifying other models similar to the Prime worker role and to provide a forum for discussion in relation to some of the findings of this study. A briefing paper was prepared outlining the study and the purpose of the discussions. The map below outlines the geographical location of the GPs responding to the email discussion group.
Nine GPs responded to the on-line discussion group from a widespread area of England, and several were very positive about the topic being explored.

*It sounds like we have many common interests* (RB)

*This sounds very good work to be doing* (SP)

*Interestingly following your email, locally we realised we don’t know who these named folk are ... I think they are probably in place ... we are checking* (ID)

One GP in particular expressed interest in the study and drew the researcher’s attention to her own published work as the lead author for several RCGP publications i.e. ‘Keep Me Safe’ (Bastable 2005a). The researcher was aware of some of this work and it was interesting to explore other relevant literature (Bastable 2003, 2005b, Bateman et al 2003). Two GPs offered to meet with the researcher but due to distance this was not possible. A summary of the on-line discussion is outlined in appendix 9. An interesting discussion also took place with ‘The Joined-Up GP’ (Goveas 2005a) discussed in the literature review. It was fortunate for the researcher he belonged to the email discussion group as trying to contact him via the PCT area where he worked proved unproductive. He was interested in the research study and very willing to share his own work. A summary is provided below:
The system discussed in 'The Joined-Up GP' (Children Now February 2005) had been in place since 1999 and he acknowledged that it was 'something we do as an individual Practice and although it was held up as 'best practice, was not tangibly supported by any NHS body'. He described how monthly multi-agency meetings were held in the Practice and included health visitor's, school nurses, education representatives, named nurse, social workers, County child protection coordinator social services service manager. The Named GP chaired the meeting.

He acknowledged that he had unsuccessfully tried to combine this forum with other GP practices. The Practice where this initiative was in place had a Practice population of 24,000, 10 WTE GPs.

The benefits of holding regular meetings in the GP Practice was discussed and these were identified as 'earlier intervention to families ... unquestionably we achieve more cooperative working with other agencies than other Practices do ... I often listen to local colleagues talking about how 'awful social services are', when in reality we had the same issue sorted out six months ago before ... because we meet regularly'.

In respect of who he thought should be the PHCT lead on child protection issues, he stated 'I haven't heard anyone argue against GP leads on cost grounds, merely on grounds of unfamiliarity (with child protection). As Named GP for the PCT, he had identified a child protection GP lead in 60% of the Practices (n=20/35) and acknowledged that the system of Named GP worked well to support other GPs. He did not identify any other person as possible child protection lead.

He highlighted Conferences in which he had presented this initiative and the positive feedback received. He noted 'many Conference participants have contacted me subsequently, but no-one from a PCT has any money to support something on which the PCT is not assessed. He shared one of the presentations (Mowatt 2005) that highlighted: -

- Safeguarding Children as a core part of General Practice.
- It can be achieved to a level of excellence within the PHCT.
- It needs to be a commissioned service, or it gets lost among all the other really important things GPs are required to do ... like flu vaccination.

... and asked that in discussing this initiative, acknowledgment be given to the work of the Practice Team – James Street, Family Practice Child Protection Team, Lincolnshire – that it was a team rather than GP initiative.

Figure 5.2 Summary of the email discussion with the 'Joined-up GP'

The on-line discussion group was a particularly good forum for an exchange of ideas and to gain insight into systems that are in place in other areas of the Country. From this small discussion group, apart from the information from 'The Joined-up GP', it would appear there might not be a similar model to the phenomena of Prime worker as explored in this study. If there are such models, they may have not been evaluated and disseminated and this issue gives strength to the study being undertaken to provide such evidence. The
evidence produced from the email discussion where existing systems in place were more akin to the Named GP / Doctor role.

5.9 Reflection on the Method.

The interesting feature about the method is the subjective data generated, as it allowed for perspectives that may not have been discovered in interviews alone and is usefully applied for the purpose of problem solving. The qualitative approach allowed participants to talk about the realities of what is happening and a 'safer' environment to explore their own personal viewpoints and not just give an expected policy view of a senior member of staff within an organisation. This was a major consideration for not selecting a more conventional qualitative approach of interviewing. It was important in this study to understand individuals' interpretations of the world around them and is central to this organisational study where the aim was to try and understand something in its context. The method was appropriate to the study's intention to 'hear many voices' informed through the generation of the sort statements, focus group, sort process and discourse generated, and through the interviews and email GP discussion group.

The method allowed a link to chaos theory perspectives and the inductive approach to the study – patterns emerging from stepping back and looking at the whole picture not just the apparent confusion surrounding the Prime worker role, but also the future direction of how staff should be supported in primary care in relation to safeguarding children. The method allowed the apparent chaos of the Prime worker system to be explored in depth. In doing so, there was always the possibility of destabilising the existing system in order to look for emerging patterns and direction of the new order but this was not apparent.

The Q-methodology process was extremely time-consuming and generated vast amounts of data through the generation of and preparation of sort card statements, focus group, undertaking an extensive pilot, 1:1 meetings with
participants, transcribing the recorded discourse during sort and interviews. At times the researcher questioned if this was the right approach and if a more conventional method should have been employed. However, it was a most interesting and enjoyable process for the researcher. The method chosen is not widely known but growing in popularity, particularly the qualitative approach and adds to the originality of the study. It was the first time the researcher used this methodology, it was a steep learning curve and it was vital to seek and maintain support from experts. This was achieved by personal contact with prominent researchers in Q-methodology and an expert validator at the University. This was particularly important during the 'fixed v free debate' for the sort (3.12).

On reflection, there was one aspect the researcher would do differently next time. At the final stage of preparing the sort cards, the author identified two cards almost identical to two others and removed them. It may have been more appropriate to re-do all the sort cards. Statement 21 and 46 were removed just prior to the pilot. It did not make any difference to the analysis or validity of data or presentation of findings and a statistician confirmed this, but it perhaps was 'untidy' to the final statement numbering in the graphs that had to be numbered by hand.

The researcher would consider this methodology again. The Q-method is a lot more than using Q-sorts: It involves a great deal of discourse analysis, both in the work done to arrive at the statements used to make up the Q-set and in the detailed expositions and analysis of the accounts, explanations and representations obtained. All participants seemed to enjoy the Q-sort and at times there was a lot of laughing and amusement at some of statements, however this also freely generated a lot of interesting discourse.
5.10 Conclusion to chapter.

The results chapters have presented the findings of the study and illuminated the emergence of patterns and themes that were not obvious at the outset of the study. All sources of evidence were reviewed and analysed together so the findings of the study were based on the convergence of information from different sources. The following chapter commences with a framework for the development of the research study that visualises the research process and emergence of patterns and themes and provide the basis for the Discussion Chapter.
Chapter 6  DISCUSSION

FROM COMPLEXITY AND CHAOS to SHARED UNDERSTANDING & SENSIBLE ACTION.  
(Wheatley 1999)

6.1 Introduction.

This chapter will discuss and analyse the findings of the study in respect of answering the research questions and in reviewing the gaps in knowledge and questions identified from undertaking the literature review. The trigger for the direction of this research stemmed from a broad search of the literature and from the Policy Analysis and Service Development Project undertaken as part of the author’s Doctoral Programme (Smith 2004, 2005). The analysis suggests some similarities to the findings of the literature reviewed and adds new direction.

In the inductive research design of this study, the author set out to establish patterns, consistencies and meaning. Themes have been developed and built on throughout the study, initially through development of the concourse, focus group and analysis of Q-sort data. The discourse validated individual sorting stances, yet also provided generation of patterns. To enhance reliability of the findings, multiple sources of evidence link research questions, data and analysis.

The four categories defined by the focus group for the sort process were used as a framework to examine the study findings. However, the four categories that initially emerged became meshed and the findings of the sorts and saturation in the discourse data began to break down the categories into themes and patterns. These new themes and patterns emerging from the data are used as a framework for discussion. Summary points are noted in each section to draw out key issues. Figure 6.1 visualises the framework for the development of the research study.
This chapter also explores this study’s original contribution to new knowledge and the impact of the research on practice, including how research findings will be disseminated and incorporated into practice. The theoretical perspectives will be threaded into the discussion. Benson’s (1975, 1983) theoretical framework will illuminate the susceptibility of intra and inter agency collaboration to external changes such as re-organisation and competing policy agendas. Chaos theoretical perspectives will try to understand if any order is to be found.

The literature review was completed in December 2006 and it was acknowledged literature was developing in light of current legislation and policy. New literature has been incorporated into the discussion chapter.

The reader is referred back to the foreword of this study and reminded this study is set in a context of prolific organisational changes, significant restructuring and financial constraints. The discussion chapter questions whether the intention of such prolific changes and PCT reconfiguration is an intention to lose corporate memory and within it, established systems unique to one PCT.
Framework for the Development of the research study.

- Local Serious Case Reviews
- Burton's Research (1996)

**PRIME WORKER**
(1997)
'Each GP Practice will have a named person for child protection' (ACPQ)


**Audit**
Role of the Prime Worker (2005)

**Development of the Concourse**

**Review of Literature**

**Focus Group.**

**Refining and selection of the statements**

**Development of Categories**

**Q-sort**

**Analysis (1)**
Q-sort data & Discourse

**Interviews**

**Analysis (2)**
Interview transcripts.

**On-line discussion Group (RCGP)**

**Analysis (3)**
On-line discussion.

**Emergence of Patterns and Themes.**

- Communication
- Roles
- Responsibilities
- Working Together

**Benson's Model (1983) of Interorganisational Policy Analysis**

**Chaos Theory**

Competing Government Policies
Role of the Organisation.
Chaos or New Order?

Figure 6.1 Framework for the development of the research study.
6.2 Communication - 'Communication with meaning and understanding'.

One of the most significant features of the study findings relates to communication, which supports and adds to the literature already discussed. Although this section looks specifically at communication, it is also a common theme incorporated throughout this chapter. Strong views were held around communication including the impact of poor communication on child protection systems, networks and ultimately outcomes for children and families. The findings indicate more effective child protection systems are needed. This was not an unexpected finding but highlights that despite all the local and national strategies put in place over thirty years, leads to question whether any change has occurred. Childcare professionals have still not been able to solve the difficulties of communication and it is still considered a challenge locally as well as nationally. The statement with the strongest held views in the overall Sort related to the effects of poor communication.

Poor communication has been a significant factor in the historical failure to protect children from abuse and neglect (score=108/110).

Several participants discussed specific inquiry reports and all appeared familiar with key issues of the Laming Report (2003) and recurrent themes of 'poor communication'. It was outlined in the literature how Lord Laming criticised professionals for the failure of good basic practice and poor coordination. Many statements for the Q-sort relating to communication were drawn from the Laming Report (2003) and from research findings of Burton (1996), Carter & Bannon (2002) and Lupton et al (1999) and were included in this study to test out if those perceptions and results existed locally. The findings corroborate evidence provided by these authors and provide further verification to support the notion that a system should be in place in GP Practices to facilitate good communication in relation to child protection issues.
For those participants not working in the PCT being studied, statements in the category of communication received some of the highest scoring and most strongly opinionated discourse and there was overall consensus with no significant diverse sitings (+/- 20%) in all participants from within and outside the PCT being studied. The findings give significance to how the Prime worker could go some way to improving communication within and outside GP Practices in relation to child protection.

The findings indicate communication is still perceived to be a problem by professionals within the PCT and other agencies working with child protection issues and GP Practices locally, particularly relating to the sharing of information – 'The most frustrating thing is communication' (section 4.5.2). There was a strong consensus that at PHCT 'grass-roots' level, there was a need for supportive communication systems where child protection issues can be discussed. This was not an unexpected finding for those working outside the PCT being studied, although there were some unforeseen findings in that the Prime worker system was not as well known as expected within and outside the PCT being studied. It was identified that if a system has been put in place in one agency to facilitate communication, then that agency must ensure that it is widely known. The researcher had presumed other agencies, particularly social services were fully aware of the Prime worker system and this is a significant issue to take forward if the role is to continue.

The Government Policy Advisor and GP on-line discussion group (section 5.7.2, 5.8) reinforced existing problems of communication through discussion or reference to their own publications (Bastable 2005a,b, Mowatt 2005). The evidence supports the importance of effective communication and corroborates the literature reviewed, however, the discourse strongly emphasised the importance of the quality of communication and communication systems that are established rather than existence of communication alone. Emphasis was given to the value of 'face to face' communication, building of trust between professionals, PHCT staff and other
agencies - 'Communication with meaning and understanding'. This was an issue referred to in the Laming Report and reinforces the work of Reder & Duncan (2003) who illustrate understanding communication through many examples relating to Victoria Climbie. They identified that in order for policy and procedure to be implemented effectively, consideration needed to be given to the psychology of communication and gave importance to meta-communication (communication about the communication) and prioritisation to the human factors known to enhance effective policy implementation - such as face-to-face contacts and the building up of trust. It is argued whether this could be achieved effectively if the person nominated to be lead professional for child protection in GP practices was not based within the PHCT setting or had strong links to the practice, and this reinforces the work of Burton (1996:26) who 'identified the easier and more accessible the contact the more effective the collaboration'.

The findings strengthen the notion of an identified person in the GP practice to coordinate child protection issues and reinforces previous studies in the importance of at least one person in the PHCT identified to have a sound knowledge base of child protection policy and procedures and a strong link to the child protection expertise provided by the PCT. Sinclair & Bullock (2002) identified sharing of information to be inadequate because practitioners lacked an understanding about confidentiality, consent and referrals. Communication will be strengthened if this is combined with a structure where the lead professional can be kept up to date and supported and allows for the development of a central system to monitor and coordinate child protection issues in primary care and across the PCT area. The Prime worker role provides a first level forum for staff to discuss low level or 'grey' concerns. Establishing a network where concerns may be discussed at the earliest opportunity, with one person hearing those small concerns may lead to earlier intervention or referral and better coordination. This reinforces the relationship between communication and coordination presented by Reder & Duncan (2003) and draws attention to the importance of how the quality of
and the context in which communication occurs may also colour how messages are comprehended. Reflecting back to Victoria Climbie, this was clearly identified as a concern.

In relation to the current Prime worker system, it was highlighted the role was introduced in the first place because communication was not good. It was acknowledged several times in the study that although 'it was not right yet', the Prime worker system had gone some way to improving communication within many PHCTs if not across agencies. However the audit acknowledged it worked well in some practices, but the initiative was struggling in others and gives strength to the philosophy of a PCT led initiative – a system put in place and monitored by the PCT child protection team. Communication is a two way process and needs to be PHCT to PCT and vice versa, and if left to each individual practice may lead to a fragmented even non existent ‘system’ which would be difficult to coordinate and monitor. The existing PCT led system allows for regular meetings with the PCT Named Nurse to coordinate and monitor, disseminate information, share good practice and provides a support network.

The positive impact on communication of holding regular GP Practice meetings was emphasised throughout the Q-sorting process and was reinforced by GPs in the on-line discussion group who gave examples of how effective communication systems were established. It was amusing to note one GP retelling how his colleagues moaned about social services when 'we had the same issue sorted out six months ago ... because we meet regularly' (section 5.8). This example identifies how good communication can also facilitate understanding roles and building of trust. The findings support the work of Brandon et al (1999) and Burton (1996) who inferred communication failures often originated from mistrust of professional perspectives and evidence from this study reinforces the positive impact on communication for professionals meeting regularly.
It was interesting to note the different perspectives relating to the impact of organisational change on communication. Those participants working closest to clinical level had strongly held views in relation to the negative impact and gave real examples (section 5.6.4, 5.6.10). One GP in the discussion group identified the health visitor’s changing role as ‘fire fighting’. These findings are important in the current climate of prolific change and the data suggests a closer link is required to clinical level by senior staff in the organisation to monitor the concerns and reality of the impact of organisational changes on established communication networks.

It was an unexpected finding to note a difference of views relating to the impact on communication if health visitors were to be separated from the PHCT setting. Those closest to the clinical level held strong views in relation to the negative impact and gave examples e.g. the GP who has recently experienced the district nursing team being relocated centrally (section 5.6.4). However, those working more strategically acknowledged the importance of having ‘strong links, good relationships, policies and procedures’ but health visitors did not have to be based within the PHCT setting in order to maintain good communication. One of these participants commented ‘we need to put things in place to counter problems ... if good communication is going on they don’t need to be attached’ but did not give any examples (section 5.6.6). Participants working closest to the clinical level challenged health visitors being based away from PHCT setting arguing it was more than a ‘link’ that was required. Emphasis was placed on effective communication – personal communication that made a difference, trust needed to be developed and good communication could not be imposed. Emphasis was placed on communication needing to be developed to provide an environment conducive to sharing concerns and discussing child protection issues. Concerns expressed in this study relating to a possible breakdown in communication if health visitors were based away from PHCTs reinforced the GP concerns highlighted by BMA (Goveas 2007) and Goveas (2005c).
Effective communication is perceived as a priority for child protection networks.

Communication with other agencies is still perceived as a problem in GP practices.

The discourse strongly emphasised the importance of the quality of communication and communication systems that are established - Effective communication requires consideration to meta communication.

Good communication can facilitate understanding others roles and building of trust.

Agencies outside the PCT are not so acquainted with the Prime worker system.

The data suggests clinical level concern in relation to the negative impact on communication and established communication networks of constant organisational changes.

Figure 6.2. Summary points: Communication -‘communication with meaning and understanding’.

6.3 'It's everybody's responsibility'- Working Together.

The findings clearly reflect the messages from The Laming Report (2003) that safeguarding children is now everyone's responsibility and are being embedded at all levels within and across organisations. In this study there was consensual agreement that in GP practices, child protection was not the responsibility of health visitors, indeed there was a strong consensus that protecting children cannot be left to professionals alone reinforcing and acknowledging responsibilities - it's everyone's responsibility. This shift in thinking has been significant in the last 10 years since the role of Prime worker was first introduced, highlighting that each member of the PHCT now has increased responsibilities to know what to do if they have concerns about a child. 'Actually in my role, we don't do child protection' was the statement most disagreed with in the sort process (score 16/110). This was one of several statements included to test out and evidence changing responsibilities. The findings are different from those of Lupton et al (1999) who highlighted an over reliance on the health visitor to take the lead in child protection.
The existing Prime worker role provides a system for collaborative child protection working between GP practices and the PCT and provides an interface between Primary Care and Social Care. Acknowledging it needs to be a two-way process, GPs remain independent contractors and may choose not to engage actively, but it is presently in place within all GP Practices and can be built on. It was acknowledged barriers still remain and not all GP practices have actively engaged and embraced the Prime worker role (section 5.6.5, 5.6.10).

The Children Act 2004, Working Together (HM Government 2006) and local Child Protection Procedures (2006) identify the role and responsibilities for those working in the health service in relation to safeguarding and promoting the welfare of children and it is a shared responsibility that requires joint working. This study identified legislation and policy alone will not necessarily protect children, improve communication or increase collaboration and reinforces current policy guidance emphasising the importance of constructive relationships between individual members of staff, supported by the organisation. Support from the organisation was rated as important in order to maintain the innovation and whereas the Prime worker role was not mandatory if it was supported by the organisation it would more likely be sustainable thus reflecting the need for strong leadership to drive innovation. An important comment from the Government Policy Advisor was the Prime worker system was 'trying to operationalize the law' (section 5.7.2).

Participants in the study working with the Prime workers and closest to the clinical level were very clear about the benefits of establishing and maintaining a system. The GPs from the email group were clear in relation to the benefits within their own PHCT and gave a high profile to establishing child protection systems. These findings support previous research identified in the literature reviewed for this study.

In this study there were less extreme sitings and views around 'roles' than any other categories in which the participants were asked to sort statements.
These findings could indicate participants did indeed hold less strong views; however it could also be argued it could indicate an uncertainty about roles. This is reflected in the discourse and sitings across all participant groups. Smith (2001) identified understanding roles was clearly linked to understanding responsibilities and identified a lack of understanding roles as a block to effective working together. Poor knowledge of other people’s roles may lead to presumptions and stereotyping. It is not clear or required to answer within this study, but may be an area for further study.

As identified in the previous section, one of the important findings of this study has been to identify that whereas the role of Prime worker is valued and seen as necessary, it is not well known to other agencies. Several participants expressed surprise such a system had been in place for nine years and commented work should be undertaken to inform other agencies. They highlighted with examples the difference it would have made if they had known they could contact a Prime worker to facilitate communication. Although unfamiliar with the particular role of Prime worker, credence was given to the philosophy and that it should:

Facilitate more effective multi-agency working ... it's the government agenda (R2).

It was noted whereas many participants in the PCT were aware of the Prime worker existence, either through being a Board member or direct links to PHCTs, they acknowledged this might not be so for other staff across the PCT and in Primary Care. This finding supports the evidence from the audit (Smith 2005) where 14/55 primary health care team members in the audit were not aware of the existence of the Prime worker.

6.3.1 The role of the GP in Safeguarding Children.

This study is not about GPs but how the primary health care team can be supported in their role of safeguarding children. However, GPs have an important role as employers in ensuring effective systems are in place. The precursory discussion in chapter five indicated there was more discourse
generated around the role of the GP than any other topic and supports previous findings from the literature that GPs are still struggling with active engagement in child protection – or at least perceived to be struggling. It was interesting to note 8/16 least congruent scoring statements were related to GPs role in child protection (table 5.1). There were clear arguments presented that some GPs are proactive in child protection and those working in the PCT being studied perceived things were changing; yet those outside the PCT viewed GPs as still being on the periphery. The evidence presented in this study is more positive than previous research, but links to the work of Burton (1996) and Lupton et al (1999) that GPs are still working within a context of high workloads, broad clinical responsibilities and increasing target driven competing demands and gives strength to their recommendations to identify a lead professional and the innovation of Prime worker. The PCT began to put those recommendations in place in 1997 and evidence emerging from this study indicate the present system of lead professional supports GPs in their safeguarding role and facilitates communication and it can be argued this is a future strategy the nPCT should consider during reconfiguration and service redesign.

GP practices operate differently and no two practices will be the same, but they are all required to work closely and collaboratively with the PCT. This poses difficulties when trying to establish a system within organisational geographical boundaries. Yet GPs are currently held to account more than previously. Activities have come under greater scrutiny in order to demonstrate performance and payments that support policy implementation. The PCT has put a system in place and the findings of this study supports previous research in identifying GPs are still perceived as a weak link in child protection networks. Lupton et al (1999:166) identified a disparity between the expected (or perceived) role of GPs in child protection and the actual roles being performed and how this contributed to role confusion and 'low levels of positive evaluation'. GPs reported to be clear about their role but they perceived their role as 'the initial stage of identification' and the health
visitor’s role in child protection was more significant than their own. The findings of this research support the findings of Lupton et al (Ibid), particularly the views of other professionals (not the GPs in the study) who perceived GPs to have a significant role in child protection yet low engagement. On reflection, it needs to be acknowledged that although GPs see a lot of children, child protection represents a small part of GPs work – on average two child protection cases per year (Bastable 2005:4). This is also acknowledged in the work of Burton (1996) and NSF for Children: Key Issues for Primary Care (DH 2004e:3). There are links here to current national policy guidance that continues to emphasise the unique position and pivotal role of GPs in child protection (Working Together, HM Government 2006). The Royal College of General Practitioners (RCGP) in 2005 reinforced this pivotal role in their strategy document ‘Keep me Safe’. The strategy emphasizes the fact that GPs remain the first point of contact for most child health problems. This strategic view, rather than the GP individual view is reiterated in government policy creating a ‘policy performance gap’. This is still an important point to be acknowledged.

There was evidence from the email discussion group that GPs in other areas were taking more of a proactive role than was evidenced from the findings of the concourse development, Q-sort and discourse generated during the sort process. It is argued the findings from the email discussion group are based on individual interests in child protection and pockets of developed child protection systems and networks rather than based on local policy with an equality of standard across that PCT geographical area. It was acknowledged by several on-line GPs such systems were set up by themselves just for their practice, it was not an indication of common practice across their PCT geographical area. Mowatt’s (2005) conference presentation through the RCGP, recommends a lead professional be identified for safeguarding issues within the GP practice. Through the email discussion group he was questioned as to how the initiative of ‘a joined up GP’ (Goveas 2005a) had been disseminated across the PCT. He acknowledged that it was voluntary and
individual practices set up systems as 'good practice' rather than a PCT led or coordinated system.

Bastable (2005a) in the work undertaken for the Royal College of GPs, supports a more active role for GPs and identifies the current need for GPs to participate in more multi-agency training and emphasises the importance of training in breaking down barriers, perceptions, blocks and understanding roles. This viewpoint was also valued by the 'joined up GP' (Goveas 2005a) and on-line discussion group (section 5.8). The findings in this study identify those working outside the PCT being studied held stronger views that GPs were still perceived as the professionals most unclear about the role of others within the child protection process and this data justifies a recommendation to the PCT Designated Doctor to incorporate the RCGP strategy for child protection (Bastable 2005a) in the PCT Business Plan. The findings give support to recommendations of the RCGP strategy in that PCTs need to support the development of GPs who wish to become Practice leads in child protection. The need to promote and raise the profile of the GPs role in child protection could be challenging for the PCT being studied and in the context of current financial difficulties and restraints, a reflection on one of the interview comments raises immediate apprehension. The response to a question relating to whether the PCT would consider financing the development of GPs to take on an enhanced role in child protection, the response was 'what is the evidence GPs are going to make a difference?' (Section 5.7.1), clearly there is work to be done.

It has been acknowledged GPs are running a small business, however throughout the study, there was constant reference through the discourse and strongly held views through statement scoring, that GPs had to be paid to do anything. These views were strongly held right across the high profile Q-sort participants and interviewees in the study. At the inception of the NHS, Nye Bevan’s line 'if I want to get a message to Doctors, I write it on a cheque' may have appeared cynical at the time, but evidence from this study identifies this is how they may still be perceived. GPs remain today at the heart of
national and local policy making, dominated by finance and incentives and where it is still easy to view primary care as the province of the GP. Money was also highlighted via the GP email discussion group, "the threats to the current Named GP system in place: money was a constant battle" (figure 5.2). This concern was not so clearly evidenced in Burton (1996) or Lupton et al's (1999) studies and appears to have developed within the last 10 years, although Lupton et al (2001:135) gives some indication GPs' contributions to child protection are unlikely to be successful unless they are manipulated through government incentives or sanctions. The possible reasons for this will be discussed in the next section and it is believed by the author not to be a local perception.

Throughout this study and supported by the literature presented, it was apparent GPs were perceived as overwhelmed by change with a strong focus on target driven, financial rewards and this led the researcher to question whether child protection had really been put on the back burner and if there are any truths to these perceptions. This notion (whatever the reality) gives strength to the existing Prime worker role to be led by the PCT — 'If it keeps child protection alive' within primary care, it must be a good thing.

6.3.2 Reflection on Benson's Theoretical Perspective — (1)

The ethos for developing the Prime worker was to improve inter and intra organisational working. Success for the national 'Working Together' (HM Government 2006) central policy guidance depends crucially on the relationship between those responsible for policy implementation at a local level. Lupton et al (2001) identified how Benson's (1975, 1983) four dimensions of equilibrium offer a helpful framework to assist in understanding the impact of external factors on internal dynamics of a network. The network or system of Prime worker appears susceptible to changes from a national and local level and it is helpful to draw on the approach developed by Benson.
Benson describes two concepts, the first centres on the patterns of network interaction and is understood in terms of the achievement of equilibrium across four key dimensions: Domain Consensus, Ideological Consensus, Positive Evaluation and Work Coordination (figure 2.4). Benson argues where networks are in strong equilibrium, communication will be characterised by highly coordinated interactions based on consensus and mutual respect. Agreement is made with Benson's broad hypothesis that the components of equilibrium are related and as Lupton et al describe:

... improvement (or decline) on one dimension will bring improvement (or decline) in others and significant imbalances are possible and affect the operation of the network (Lupton et al 2001:16).

The findings of this study acknowledge the Prime worker system is 'not right yet', but has come some way since inception and markedly within the last two years. The precursory audit to this study (Smith 2005) indicated there might have been some degree of forced coordination leading to a notion of apparent chaos or disequilibrium. This study identified a need to raise awareness of the role in order to bridge any ideological and domain inefficiencies and to strengthen work coordination in the context of a positive evaluation for continuation of the role.

To an extent, the evidence suggests a reasonable degree of domain consensus surrounding the roles of specific groups in child protection, particularly in relation to responsibilities. A central matter of the Working Together guidance (HM Government 2006) is to encourage consensus on both domain and ideological dimensions (who does what and how it is done). Lupton's et al's study (1999) clearly identified the importance of understanding roles and responsibilities for effective equilibrium of networks. This study identified there may still be weaknesses in domain consensus through understanding roles. However, it could be argued roles and responsibilities should not be unclear as guidance produced by core policy communities (LSCB / HM Government 2006) is more specific than ever before and led by legislation. The policy community requires a degree of ideological
harmony and reciprocity and the Prime worker system set out to achieve this and improve communication and work coordination. Emphasis has been placed on the need for high levels of work coordination in order to achieve and sustain the equilibrium required and this study has highlighted potential threats to achieving this in the future. Factors external to the network may operate to disturb this equilibrium on any or all of the key dimensions and impair the ability of professionals to contribute effectively.

This study has also evidenced that to an extent domain dissonance still exists in how GPs view their role and the way in which others perceive their role. This reaffirms the findings of Lupton et al (2001:162) and is a major factor in domain disequilibrium that may also serve adversely to lower the level of positive evaluation that exists between ‘network’ participants. However, from the email discussion group there was evidence of some high degrees of domain and ideological consensus, positive evaluation and work coordination through GP led initiatives and strengthens a recommendation to the PCT to embrace the RCGP five year strategy for child protection.
### Summary points:

- Safeguarding Children is everyone’s responsibility. This study provided evidence that this is being firmly embedded across all levels within the organisation being studied.
- Poor knowledge of other people’s roles may lead to presumptions and stereotyping and this may be an area for further study.
- There remains a dissonance in expectations of GPs role in safeguarding and an apparent policy performance gap in the expected (or perceived) role of GPs in child protection. This may contribute to the role confusion and ‘low levels of positive evaluation’.
- Legislation and policy alone will not protect children, improve communication or increase collaboration. Importance is given to developing constructive relationships between individual members of staff, supported by the organisation.
- The existing Prime worker role provides a system for collaborative working between GP practices and the PCT, and provides an interface between primary care and social care.
- Those closest to clinical level were clear about the benefits and importance of having a child protection lead in each GP practice.
- Support from the organisation and strong leadership was rated as important to sustain the innovation and reach 100% of GP practices, rather than having isolated pockets of good practice.
- The present Prime worker system attempts to operationalise the law.
- The data in this study reinforces the findings of the Audit (Smith 2005), in relation to the need to raise awareness of the Prime worker role across the PCT, primary care and wider stakeholders.
- GPs should be targeted to participate in multi-agency training events.
- There were strongly held views that GPs had to be paid to do anything.
- Challenges have been identified in getting the PCT to acknowledge a clear role for GPs in safeguarding children. There is a need to give a high profile than presently presented. The PCT through the Designated Doctor should consider incorporating the RCGP Strategy and developing the role of GP with Special Interests in Child Protection.

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6.4 The Role of the Prime Worker – Necessity or Luxury?

6.4.1 The value of a Prime Worker Role.

This study is focused on the innovation of the role of Prime worker for child protection in primary care and relates directly to answering three of the research questions that ultimately pose the question ‘is it a luxury or necessity for the PCT being studied’? The study seeks within it to evidence whether the role has value and whether the present model should be continued.
The current system is supported by the PCT protocol and standards introduced in 2005 to augment the role (see appendix 2). It was identified in the literature at the outset in 1997, when the role was launched across the County, yet, by 2004, only one PCT (one of five) acknowledged the role of Prime worker was still in existence (section 1.2). Fraher’s study in 2001 (page 9) identified the Prime worker role could make a valuable contribution to child protection processes in GP practice and that it should be continued, yet none of the recommendations from the study were taken forward. Initially the Prime worker was designed to be a role for a nominated GP in each PHCT, but this initiative was not taken up by GPs and the role devolved (as at 2006) to 100% Health Visitors.

This study provides strong evidence that the role is perceived as important and should be continued in order to coordinate and improve communication relating to child protection within the PHCT. There was overall concurrence that each GP Practice must have a lead child protection professional. However, it was noted that two participants did not disagree but sited ‘no opinion’ which was surprising as one respondent had a high-level strategic child protection role outside the PCT being studied. Those working closest to clinical level with experience of working with the Prime worker gave most credence to the role but identified there were still improvements to be made and the profile raised. Evidence suggests the role should be formalised and not as present, an ‘add on’ for senior health visitors. There was strong recognition the role should also be incorporated into job descriptions and clearly, if it is to be continually led by health visitors; this should be given urgent consideration. In the light of the transference to Agenda for Change, this is important and consideration has been given to the wording that could be incorporated into a generic health visitor job description – The researcher proposes ... ‘You may be asked and would be expected to undertake the role of Prime worker for child protection within a primary care setting’. Lack of formal recognition of the role in job descriptions may be one reason the role
lost momentum in other areas. Acknowledging the role adds value to the role and confirms support from the organisation.

In respect of the statements around incentives or rewards in order to undertake the role of lead professional for child protection, it was unexpected to note that valuing and supporting the role rated much higher than financial incentive. Several participants viewed the lead child protection role as a key function of the health visitor but emphasised the role should be supported and led by the organisation. There are some interesting links here to the work of Fineman (2000:4) in relation to ‘emotional labour traps’ and Smith (1992) in considering how much of the Prime worker role until now has been considered emotional labour – a duty and conforming to a set of rules.

There are significant links to the research and recommendations of Burton’s (1996) study that identified ‘consideration to financial reward’ as important. However, this has not been borne out in this local study as discussed above, but identified as an important aspect by the GP on-line discussion group. In exploring the future direction of the Prime worker role, consideration needs to be given to the reality of financial reward in a cash-strapped NHS Service in the middle of reconfiguration and the focus should be on valuing and supporting the role.

Continuation of the existing role of Prime worker was given strength by the County Lead Director for Child Protection who stated consideration should be given to the importance of the role in future workforce planning and reconfiguration. From the findings of this study it is proposed the present Prime worker system (standards and protocol) should be a basic requirement for all PHCTs as the five PCTs are reconfigured.

The email GP discussion group gave value to the development of a lead professional for child protection and this is promoted through their recent Royal College of GPs strategy document (Bastable 2005a). The Government
Policy Advisor also endorsed the value of a Prime worker role (section 5.7.2) and expressed interest in the findings of this study that may influence future national policy.

In December 2006 as the study was in progress, the Local Safeguarding Board updated and re-launched the County Child Protection Procedures. Within these new Procedures significance is given to 'It is good practice to identify within the primary health care team, an identified professional who takes the lead role with regard to child protection concerns' (Section 9.9.33) – therefore indicating that it is not luxury but necessity. In relation to current legislation, the Prime worker has an important role in working towards promoting and safeguarding the welfare of children.

You know ... I think the Prime worker role makes a difference to children 
(R10).

This study has provided evidence the role is needed - it provides a communication pathway and supports the PHCT in 'keeping child protection alive'.

During the final stages of writing this study the researcher became aware at a national conference of a research study in progress entitled 'Safeguarding Children in Primary Care: Confronting the challenges' (Appleton 2007). This as yet unpublished research explores how primary care organisations manage and deliver their safeguarding responsibilities in relation to national policy. The study was undertaken from December 2005 to May 2006 via a national telephone survey and recorded semi-structured interviews with sixty Designated Nurses. There are some similarities in the emerging findings to the researcher's study:

- Healthcare professionals in primary care organisations must reach vulnerable children.
- Lack of understanding of professional roles identified as still an issue within and across primary care organisations.
Evidence of poor communication and information sharing.

Findings contributed to understanding the challenges faced by primary care organisations in delivering safeguarding children's services.

GPs, although perceived as being difficult to engage, are beginning to take on board their child protection responsibilities.

The above study was undertaken prior to PCT reconfiguration and it could be argued the findings may indeed appear more chaotic now in 2007 than 2005/6 as indicated in this study and from anecdotal evidence from other senior child protection nurses across the region. However, these findings would indicate the Prime worker role would go a long way to address some of the issues identified.

6.4.2 The person to undertake the Prime Worker role.

It has been acknowledged that at the outset, the GP was initially identified as the most appropriate person to undertake the role of lead child protection professional in GP practices. It was not surprising this did not happen as in 1997 and 1998 when the initiative was being established; the evidence from Lupton and Khan's (1998) study was emerging in relation to health professional's role in child protection.

In this small local study there was no evidence child protection was not taken seriously or viewed as important by GPs, however evidence indicated GPs are still perceived as having little time, experience or training for child protection and this was most strongly identified by those participants working in safeguarding within and outside the PCT being studied where strong emphasis was placed on the difficulties of communication. It was surprising to note from the Q-sort data, the person perceived best to undertake the role of Prime worker was not the GP (score 38/110) and 'any member of the PHCT could undertake the role...' held stronger views (57/110).
In respect of GPs undertaking the role of lead professional for child protection, although not given credence in the findings of the 'organisation' being studied, the on-line discussion group certainly provided evidence of excellent GP led systems in other parts of the Country. It is acknowledged these were all GPs with Special Interest (GPwSI) and it is to be expected they would argue against some of the findings of this local study, but they gave examples of pockets of established good practice where systems are set up in GP practice. The GPwSI is likely to be the PCT Named GP, offering advice and support to other PHCTs and Local Safeguarding Children Boards, but the role does not reflect the same 'grass-roots level' system set up in every GP practice this study is exploring. The GPwSI is more akin to the Named Dr role and requires significant financial investment.

In considering the best person to undertake the role, it is important to refer back to other key issues of this study, particularly the discourse identifying it should be someone accessible, someone with whom a relationship of trust has been established and someone who was interested in the role rather than the role imposed (section 4.5, 5.5.2). Certainly in this study health visitors were perceived as having a high interest in child protection matters and this is reflected in the findings of the precursory audit to this study (Smith 2005).

In Lupton et al's study (1999), health visitors were perceived to have an essential role in child protection and this was reinforced by the high scoring in this research study where health visitors were still acknowledged as having a high degree of involvement in child protection matters. There were mixed concerns expressed about the 'loss' of the health visitor to primary care teams, changes in visiting patterns and the concern health visitors may not be seeing families and therefore missing concerns. These mixed findings were unpredicted as the researcher had assumed the statement 'health visitors should be attached' would have held stronger views. It certainly did for those working closer to the clinical level and generated a lot of discourse expressing
concerns particularly in relation to the impact on communication, whereas others working at a strategic level more distanced from primary care.

In the organisation being studied, health visitors were still based within the PHCT during the data collection phase of this study. However, there are plans to remove health visitors to more central health visitor teams with the intention they will ultimately move into Integrated Service Teams based away from Primary Care locations. This has been established across some areas of the rest of the County and it is the researcher's personal view that this has contributed to the breakdown of the Prime worker system in other areas. Consideration needs to be given to whether health visitors are still perceived to be the most appropriate people to undertake the Prime worker role, how can this best be achieved and raises the question whether the present system would be compromised if health visitors were based away from PHCT's. This has not yet been tested but could have the effect of pulling health visitors away from current strong primary health care team links. However, a GP in the on-line group acknowledged the health visitor as best placed in PHCT's and also expressed concern about changing role to 'fire fighting' (section 5.8). There is a danger of health visitors not being seen as an important member of the PHCT and the impact of losing the health visitor through more integrated working with other agencies could result in loss of available support, knowledge and expertise to the PHCT.

If health visitors were distanced from the PHCT, the PCT would need to invest financially in training and supporting the development of GPs with Special Interest in child protection. This may not be imminent but a long-term consideration. Reference is made here again to a comment from one of the interviews: 'what is the evidence GPs are going to make a difference here', providing evidence the PCT is not quite ready to relinquish the established Prime worker system, free at the point of delivery.
It is important to acknowledge for GPs to engage fully in child protection processes (for every child on a GPs caseload) although such an ideology may never be reality across all GP Practices due to issues already highlighted. There is no question GPs must be encouraged to take responsibility for identifying and referring child protection concerns. Yet, it still raises the question of how can GPs be more effectively supported in their safeguarding role in the PHCT.

There is no evidence to suggest a GP could not be a Prime worker within the existing system. Indeed, an alternative to the existing health visitor undertaking this role (100%) may need to be considered if health visitors continue to be distanced from PHCTs into the wider national and local policy agenda of Integrated Children’s Services. It is important to reflect back to 1996 when the original intention by the local Health Authority was that the Prime worker would be a GP – they all said no.

The person to undertake the role in the future was questioned by the Government Policy Advisor who acknowledged the existing system appeared to be a good model. She questioned how many health visitors were still attached and stated:

That’s an argument for not taking health visitors out of GP Practices isn’t it?

The findings reinforce the work undertaken by Lupton et al (2001:150) in making the recommendation the health visitor is still the most appropriate person to undertake the role.

... Designate the health visitor as the PHCT representative and key workers in the child protection process ... this would clarify responsibilities and legitimise the role that, de facto many health visitors already assume.

If this is seen as a valuable part of the health visitor’s role that until now has not been clearly acknowledged in the PCT being studied and from wider stakeholders, then in the present climate of change and ‘confusion’ around
the future role of health visitors, this must clearly be highlighted. Does it
matter who undertakes the role of lead professional for child protection? This
study is about exploring a phenomenon in existence. The role has been
identified important and it is still practical to consider the health visitor as the
most appropriate person. In the current climate, health visitors need to hold
onto what is important about their role although it could also be argued as
health visitors trying to defend their traditional domain. There is prolific
research around about communication, and it should not matter who as long
as PHCT’s take ownership of their responsibilities and the PCT is willing to
provide support networks and leadership to help sustain the role.

6.4.3 Reflection on Benson’s Theoretical Perspective (2).

This study provides positive evaluation of and identified the Prime worker role
is necessary, and that the health visitor is best placed at present and the
most appropriate to undertake the role where a protocol and standards are in
place to support that role (strong domain and ideological consensus).

Potential barriers to the sustainability of the role have been identified. A range
of internal and external factors threatening the ideology and domain
consensus, work coordination has been identified. The reader is reminded the
role was established to readdress an imbalance in work coordination and
positive evaluation. Positive evaluation to the ideology of the present Prime
worker role was clearly identified in this study. The development of a protocol
and standards provide this but consideration of how equilibrium is currently
being affected by a weak ideological consensus evidenced in the role is not
widely recognised as initially perceived by the author. Awareness of the role
needs to be raised within and outside the PCT being studied in order to
strengthen work coordination.

The evidence presented shows a reasonable degree of domain and ideological
consensus (who undertakes the role and how it is done) Consideration may
need to be given to possible realignment in order to prevent future disequilibrium of work coordination, domain and ideological consensus if the present Prime workers (100% health visitors) were removed from bases within primary health care teams. Evidence is made here to 'the elasticity of the health visitors role' as described by Lupton et al (2001:177) that continued pressure remains on health visitors to make a greater contribution to child protection in addition to increased demands of individual caseloads, community development work in the context of fewer numbers.

From the audit undertaken by Smith in 2005, there appeared some disequilibrium that may have been caused through forced coordination when the role of Prime worker was initially established without clear protocols, standards or formal acknowledgement (i.e. in job descriptions). There has been some subsequent realignment but it is acknowledged through this study further realignment is required in order to enhance positive evaluation (particularly by those undertaking the role) is key to sustaining innovation which has been identified to be valued and should be continued and developed.

Summary points:

- The Prime worker / lead child protection role within PHCTs is valued and should be continued.
- The PCT has put the system in place and supports the continuation of the Prime worker role. However, it acknowledges that each GP practice is different and in some, the Prime worker role will be embraced and actively work to safeguard and promote the welfare of children, others may not be so well received.
- The Prime worker role is not widely known and should be re-launched to raise the profile and awareness across the nPCT and to wider stakeholders.
- The Prime worker role should be formalised within job descriptions.
- At the commencement of this study, health visitors were perceived as the most appropriate to undertake the role of Prime worker and this has been borne out of the findings from this study.
- The present Prime worker system may be compromised if health visitors were based away from primary health care teams.
- The PCT to consider the future resource issues in sustaining the role of the Prime worker in relation to Integrated Service Development and health visitor attachment.
- The PCT needs to give consideration to developing GP(s) with Special Interest in Child Protection.

Figure 6.4. Summary points: The role of the prime worker – Necessity or Luxury?
6.5 ‘Drivers or resisters?’ – The perceived impact of Government policy on Child Protection systems in Primary Care.

It became apparent in the course of data collection and analysis there was evidence of different government policy drivers impacting on the innovation of Prime worker as it exists and may account for some of the perceived views in relation to GP’s role in safeguarding children. Some of the driving forces also appear to be resisting forces – pulling against each other to present apparent chaos rather than order, in being able to be clear about the future direction of the Prime worker innovation. Figure 6.5 identifies some of the driving forces to the development and maintenance of the Prime worker role within GP Practice and identifies some of the resisting forces to the stability of the present format.

Figure 6.5. Driving forces to the Prime worker innovation and resisting forces impacting on stability.

Following the initial analysis of Q-sort data and discourse generated during the sort process, the author began to question the reality of some of the emerging findings and sought interviews to clarify and validate some of these
issues of whether the legal requirements of the Children Act 2004 and policy guidance of Working Together (HM Government 2006) were being subsumed by the political drivers of the NHS. This did not appear to be an issue of significance in other research studies explored in the literature. The first interview was very revealing to understanding the emerging new knowledge and illuminated the fact government policy drivers could be impacting on how GPs are perceived: ‘you have to be paid to do anything’.

6.5.1 Working Together or Pulling Apart? – Interpretation on competing Government Policy Agendas.

It appears through the findings there are difficulties with competing targets and policy agendas at a national and local level and genuine concerns regarding getting children’s services onto the agenda (Section 5.5.1, 5.6). The government policy advisor also identified competing policy agendas within government departments and difficulties of getting issues ‘onto’ the agenda. Issues that came onto the agenda had to be at the expense of others coming off (section 5.7.2). The Government Policy Advisor and Royal College of GPs gave examples of the difficulties incurred in relation to additions to the Quality Outcomes Framework (section 5.7.2, figure 5.2 and appendix 9) and how ‘no one from a PCT has any money to support something on which the PCT is not assessed’ (Personal communication, Mowatt 2006). The author questions whether Government Departments ever reflect or evaluate the impact of their own competing policy agendas.

6.5.2 The Prime Worker role and the broadening Safeguarding agenda.

This study reinforces previous research in identifying the health visitor having expertise in child protection, and since 1997 has been seen as the most appropriate person to undertake the role of Prime worker. Yet, there is a policy driver that may be taking the health visitor away from the PHCT - The Every Child Matters Policy agenda: transforming delivery and coordination of services. The Prime worker system operates within a wider network and this
study has identified positive evaluation to the role from a wider stakeholder group. The role of Prime worker allows sharing of knowledge and skills and the health visitor was identified as having a strong link to GP Practices particularly in relation to child protection networks.

A significant driver of change in the Every Child Matters Agenda includes developing Children's Trusts arrangements, joint commissioning and cooperation between partners across local authorities and health. The emphasis of the Government Public Health White Paper (DH 2004c) and 'Our Health, Our Care, Our Say' (DH 2006b) is on becoming healthier in a 'neighbourhood family' context from a locality base, rather than working from a GP surgery where focus is around an individual person in an individual context. At this present time the Children Trust and PCT are planning the Integrated Service Delivery Programme where health visitors will be located in areas that facilitate the easiest access to children and young people, regardless of whether it is a GP practice or community based unit. This supports the views of the Royal College of Nursing and Community Practitioners & Health Visitors Association that future locations for health visitors needs to be locally driven based around the needs of children and their families (Goveas 2005c:10). At this present time, health visitors in the PCT being studied are still based in PHCT's and ideally placed to undertake the role of Prime worker. Arguably, with the planned move to Integrated Service Delivery Teams there appears a conflict between the health visitors role in primary care and that a pull in one direction will work to facilitate a more integrated approach to the needs of families and children but it is pulling in another direction away from the PHCT where the health visitor has an established role and is valued as a safeguarding children lead. Agreement is made here to Lupton et al/s comments (2001:150) the 'elasticity of the health visitors role presents problems as well as opportunities'.

The full impact of health visitors being based away from the PHCT has yet to be discovered in the PCT being studied. This is occurring in other parts of the
Country and County, despite a British Medical Association (BMA) national conference (2005) where GPs rated overwhelmingly that health visitors and district nurses 'should always be attached'. This issue is currently being debated through 'Facing the Future: A review of the role of health visiting' (DH 2007a) and difficulties noted in Health News, Children Now, June 2007. Whilst the participants in this study acknowledged the role and value of the health visitor to child protection systems and networks within the PHCT, they placed more emphasis to establishing effective communication systems and information sharing rather than being physically attached.

The consultation document 'Commissioning Framework for Health and Well Being' (DH 2007b) takes the direction of change a step further with the proposal to link Practice Based Commissioning (PBC) to Children Trust arrangements. This raises some concerns about how can it be assured PBC and Children Trust arrangements work effectively to improve outcomes for children. It has already been noted the minimal requirements for child protection within the nGMS Contract. PBC for children is at an early stage and it is not yet clear where child protection arrangements fit into this. A positive outcome of the proposed commissioning arrangements could see health visitors returning with a stronger link to Primary Health Care Teams as Commissioners work closely together. For child protection this includes close monitoring by the Local Safeguarding Children Board (LSCB). The LSCB may have an important role in influencing future child protection commissioning arrangements and it has been important in this study to include views of wider stakeholders. What also appears positive is the notion of GPs being able to Commission as part of the Common Assessment Framework.

The Children Trust and Integrated Service Development Programme has a vested interest in ensuring that there are strong links to GP practices. Health visitors at present are viewed as providing that social care / health link. This study identified that in other areas systems have been developed where GPs undertake an increased safeguarding children role, yet this study has not
explored fully the financial implications of this. Whatever the future direction of the integrated world, what is important in this study is that the GP practices and PHCTs have a child protection lead.

Throughout this study, the author has been careful not to overuse the term lead professional as in wider safeguarding terms, it implies a different meaning.

6.5.3 The GMS/nGMS Contract and The Quality Outcomes Framework.

The data suggests strong views are held that 'policy does not necessarily lead to change ... but payment does change behaviour in some people’ (Section 5.6). Money could therefore be perceived as having more importance or influence than policy? This study acknowledges primary care appears overwhelmed with change and target driven agendas – but has child protection really been put on the backburner? It was not perceived in this study that the National Service Framework for Children and Young People (DH 2004b) would have a major influence. It was perceived as a political driver for change and better outcomes for children but unlike other NSF’s it is not target driven, and therefore is less likely to give the Children’s agenda a high priority and this has already been criticised within the data of this study (section 4.5.4, 5.5.3) and demonstrated in the requirements of the Quality Outcomes Framework. However, the NSF may have been a missed opportunity, particularly in Standard 5, as it could have specified the need for a lead professional for NSF to be identified, particularly in the NSF: Key issues for Primary Care document (DH 2004e), especially in light of research evidence already published by Burton (1996) and Lupton et al (1999). 'They are small businesses’ was consistently noted throughout the discourse generated and interviews undertaken and appeared to distract from safeguarding responsibilities and highlighted the need for the PCT to coordinate and monitor child protection systems through their responsibilities as Commissioners in line with Section 11 Children Act 2004.
The impact of government policy over the years has resulted in changes to how GPs are perceived, or indeed reinforced the perceptions that GPs do not engage well in child protection coordination. Striking in this study were perceptions that GPs ‘have to be paid to do anything.’ Some Q-sort statements and discourse generated were distractive in relation to the GPs role in safeguarding children and the perceived views that ‘GPs would only do anything if they were paid’. This appeared to take the focus away from ‘responsibilities and accountability’ – GPs like any other health professional have to work within the legislative framework and statutory guidance. In the study, only one participant in the Q-sort (R1) and one of the interviewees identified the statutory responsibilities of GPs in safeguarding children.

At this stage in the discussion, the researcher questioned whether in generating the statements, the journalistic bias and professional perspectives had impacted on and distracted from reality. GPs were certainly perceived as only being interested in financial reward and this could also be perceived as a block and barrier to effective working with other professionals, yet this finding was certainly reinforced in the study across all data collected. The one GP in the Sort group challenged these perceptions but acknowledged it is how GPs may be viewed. All other participants held strong views that GPs were more likely to engage if they were paid. All GPs in the on-line discussion group were being paid to undertake the role of GP with Special Interest (GPwSI). However, in the PCT being studied there was no real evidence there was a barrier developing with GPs in relation to funding to work more effectively in child protection and this raises the question is this because there is a Prime worker system in place?

The impact of the GMS Contract appeared important in the developing notion that GPs had to be paid to do anything and how the GMS contract and Quality Outcome Framework (QOF) appeared to distract from the key issue of ‘legal requirement’. There were strongly held views across the Q-sort statement siting and in the discourse, GPs had to be paid to do anything also identified
that in the GMS Contract there is very little requirements for child protection (just procedures in place) and Children’s Services in general receive very little mention in the GMS Contract.

The way forward may be to strengthen the child protection requirements in the Quality Outcomes Framework. It has been acknowledged in the literature and findings of this study there are minimal requirements within the 146 indicators of the QOF relating specifically to children and only one requirement for child protection. Evidence from the GP on-line email group argued GPs base line contractual arrangements were not being monitored and the QOF element of the Contract was the part most closely monitored – ‘especially now PCTs are bogged down in the core business of NHS structural reorganisation again’(MW) and posed a question to other on-line members to consider ‘how often does your trust visit outside the QOF visit? ... they don’t seem to’(figure 5.2).

At the writing-up stage of the study, the researcher returned to Interviewee 1 to further clarify how the base contract requirements were being monitored within the PCT being studied. Point 20 of the Contractual and Statutory requirements of the GMS Contract require individual healthcare professionals to be able to provide evidence.

Evidence was produced to demonstrate core requirement monitoring through the annual QOF visit and a template developed to prompt lay assessors was examined. The template included additional requirements ‘they should be able to show you the red book’ which included prompts to question if the member of staff knew what to do if they were concerned about a child and who they could contact. The researcher was informed this provided evidence PCT staff were aware of the flow charts provided by the Prime workers and noted the Prime worker was frequently mentioned. This supports the data from the audits (Harrison 2006, Smith 2005) that the reality of a Prime worker role is being firmly embedded within primary health care teams – even if one of the drivers is to meet the financial rewards of the QOF Monitoring. The author
argues the requirements should have clear links to the legislative requirements of the Children Act 2004 and a requirement for monitoring should be 'each GP Practice has a named Prime worker for child protection' as identified in the County Child Protection and Safeguarding Procedures (2006). Monitoring of child (and adult) protection systems should be a requirement within the baseline Contract and not linked to financial reward. Present lack of clarity and monitoring appears to weaken the child protection role of GP practices. The participants in the study acknowledged difficulties for GPs in the competing target driven agendas for primary care.

The GP discussion group revealed variations of practice in what was considered Core Services within their GMS Contract and supports the evidence of Bastable (2005a:14) that it has resulted in various parts of child protection activity being funded (or not) on a very local basis. The Royal College of General Practitioners (RCGP) response to this variation was to request in the revision of the GMS Contract 'child protection be included in the clinical governance arrangements of GP Practices'. One member highlighted difficulties of getting more child protection requirements into the nGMS Contract as he had been involved in the RCGP proposal that more evidence should be required other than 'know where guidance is kept' and put forward submissions to be included for the nGMS Contract (2006/7). Two out of four submissions were rejected (figure 5.2). Likewise, the Government Policy Officer identified difficulties for the policy team with competing policy agendas and requests to include more monitoring for children and particularly child protection in the nGMS contract was turned down – 'you put something in ... you have to take something out ... it's really difficult' (section 5.7).

One GP discussed being involved in a pilot where all inspections are combined into one – QOF, Contracted, Statutory and PCT Clinical Governance targets (HC). A positive evaluation of that pilot may pose a more effective way forward in monitoring for the PCT being studied.
6.5.4 Primary Care Trust reconfiguration: Loss of corporate identity?

The NHS has undergone significant structural and process change in the last 10 years under the Labour Government. Within this study it has been difficult to keep up with the impact of such change within Primary Care and the researcher questions whether it was by design or accident that the change drivers seem to have resulted in a loss of corporate identity. The present climate of reconfiguration has led to downgrading and reduction in posts and fragmentation of the workforce and the remaining staff appear ‘fighting to hold on’ to what was important in one PCT as a bigger new organisation develops with ‘a clean sheet’. Reference is made to Beenstock and Jones (2000:29) who argue that whatever form PCTs takes in reconfiguration, it should aim to create itself into a ‘learning organisation that enables staff to make contributions not only to their organisation but through them to the wider society’. They maintain this will lead to staff feeling valued, empowered and realise their own leadership potential. Therefore it becomes vital to provide evidence to sustain innovative practice and work towards developing it across the new organisation. There will always be competition for scarce resources, competing policy drivers within the PCT – some target driven and some driven by the demographics of the population.

6.5.5 Reflection on Benson’s Theoretical Perspective (3)

It is important to acknowledge Benson’s hypothesis on how the components of equilibrium (or decline) are related, in so much as improvement in one dimension may bring about improvement or decline in another. Benson (1975:247) views Interorganisational fields as a 'political economy with different powerful organisations interacting in pursuit of scare resources of money and authority'. Where there may appear equilibrium at present, there is certain potential for imbalance in all dimensions apart from domain consensus (who does what) and particularly work dimensions, if health visitors are totally removed from PHCT bases (alignment of work patterns).
As the findings of this study are being summarised, it is clear the future directions for health visiting could cause an imbalance in the domains. Just as this study has provided evidence of equilibrium, there now appear threats. This section has demonstrated how both internal and external factors may operate to disturb equilibrium in one or more dimensions and how this could result in consensual inefficiency (poor work coordination but high levels of ideology and domain consensus, and ultimately negative evaluation). The Prime worker role is susceptible to the impact of change. Possible conflict here is in ideology and work coordination with competing policy agendas of Integrated Service Delivery moving health visitors from primary care settings.

Evidence suggests potential blocks to achieving equilibrium across the four dimensions (who does what, how it is achieved, positive evaluation and work coordination). Increased workloads and emphasis on target driven agendas, does appear to impact on the ability to achieve effective work coordination and decreases positive evaluation. Central policy drivers do appear to some extent to impact on the coordination of local initiatives and systems, particularly child protection. The findings challenge Lupton et al (2001:167) argument the child protection front line network may be 'too fluid to fit precisely into any ideal typical model of network equilibrium’in that the Prime worker initiative could and does work towards achieving network equilibrium for child protection within primary health care team settings and with wider stakeholders.
Summary points:

- The evidence suggests that competing government policy is a driver and a resister impacting on the future of the Prime worker for child protection role.
- The nGMS Contract continues to have minimal requirements for child protection.
- The evidence suggests that competing policy agendas within government departments have impacted on proposals for increased monitoring requirements for child protection in GP Practices has been denied.
- The PCT has a template for monitoring baseline requirements of the nGMS Contract. The safeguarding children requirement for GP Practices needs to be increased.
- The PCT to consider practicalities of combining inspections to GP Practices: - Quality Outcomes Framework, Contractual, Statutory and PCT Clinical Governance targets.
- NSF for Children is not target driven and it is perceived as unlikely to give the children's agenda a high profile within primary care.
- The GMS contract appeared Important in the developing perceptions and strongly held views that GPs had to be paid to do anything.
- Constant PCT reconfiguration and reorganisations have led to an apparent loss of corporate identity.

Figure 6.6. Summary points: 'Drivers or resisters?' The perceived impact of government policy on child protection systems in primary care.

6.6 The role of the Organisation in maintaining the Innovation.

The National Health Service is going through prolific constant change and reorganisation. One of the key questions running through this study is 'how do we manage constant change, yet have effective systems in place to safeguard children within primary care?' It is argued the process of constant service redesign and reconfiguration already suggests the most vulnerable may be compromised. Staff are resources and vulnerable children and their families need resources. Reconfiguration has seen a significant cut back in home visiting for community practitioners and this can make some of the most vulnerable families and children 'invisible'.

The audits undertaken by the author in 2005, highlighted there may have been a 'lack of organisational ownership' to the Prime worker initiative and that it was not taken up as a process when it was first launched in 1997. The findings support the view change is to be seen as a process rather than a
single event (or one off launch) and requires long-term support and encouragement. However carefully planned, it is almost inevitable the process of bringing about change will itself have unintended consequences and somewhere along the route, unforeseen events will be encountered which may require the initial aims and objectives to be reviewed and reframed in the light of changing circumstances. The findings acknowledge GPs and PCTs are pulled in too many different ways to meet targets imposed and are also required to meet the demands of an increasing ageing population.

The study by Lupton et al (1999) indicated how on-going structural changes in the NHS were seen as problematic in fracturing the health service, with debilitating effects on inter-agency working and the cumulative pressures adversely affected the capacity of certain health professionals to take a more participatory role in child protection. It has been discussed in this study that for GPs, some of this still remains with the pressures already highlighted, but this finding gives strength to maintaining and developing the role of Prime worker. In the study, several key people working in the PCT (section 5.6.1, 5.6.5, 5.6.6) questioned the negative impact of change on an organisation. They acknowledged organisational change as a risk to any system but it was often used as an excuse. Clear leadership and policies being in place was given more credence. Despite change in the last 10 years, the Prime worker has been a stable figure within the organisation being studied and there was no evidence from this study to support it should be disbanded. The Prime worker role was a recommendation from several research studies already identified and was developed to counteract the difficulties they described. Whatever direction the role takes in the future, it is vital that it remains simple, realistic, achievable and sustainable. With the shift to developing Integrated Services, planners from all agencies need to learn from innovative practice if a broad based preventative approach is to be achieved and then incorporated into future plans.
This study provides evidence of organisational commitment and value to maintaining the Prime worker initiative. Evidence was provided from the Chief Executive and PCT Directors to support continuation of the role, but also acknowledging difficulties and support that is required to sustain the system.

*I think it is a KEY* role ... it is about raising profile of that member of staff ... but also recognising some primary care teams are going to accept the role it with more enthusiasm than others ...therefore support networks we put around those staff doing the Prime worker role in the more difficult circumstances is so important* (Director in PCT).

In supporting the innovation, the benefits to the organisation are evident. With the system already established, nominating a lead professional within the PHCT is free at the point of delivery. To ask GPs to undertake the role, or develop extensively the role of GPwSI would not be financially viable to the PCT at this present time. A Prime worker system already exists with the people who have the skills and knowledge to undertake the role and it already reaches out to all GP practices and provides an important child protection link in both directions. If it remains PCT led there is equality of provision across all GP practices, although in reality, engagement with the role may be variable but at least the organisation can monitor and continue to evaluate the effectiveness of what has been put in place. However, this study has identified that if GPs are still perceived to be a weak link in the child protection system, the PCT must also look at a strategy to fortify the GPs role.

By the PCT Chief Executive, Directors and Senior Managers supporting and monitoring the innovation, they are able to provide evidence to the Safeguarding Board, SHA etc in relation to meeting the requirements of Section 11 of the Children Act 2004 (ensuring that functions and services provided on their behalf are discharged having regard to safeguard and promote the welfare of children). Certainly there is evidence of organisational commitment and accountability structures in place for safeguarding children.

* Denotes participant voice emphasis.
that identify the PCT is far removed from the comments made in the Laming Report (2003) about widespread organisational malaise.

In answering one of the research questions for this study, supporting and maintaining the innovation, works towards serving the best interests of children but also the interests of the organisation (protecting children and protecting the organisation). In considering the way forward for the future Prime worker role, consideration has to be given to how the innovation will be sustained now there is evidence it should be continued.

6.6.1 The role of leadership in maintaining the innovation.

The role of leadership in maintaining the innovation is to gain evidence of value to the organisation and to reflect on the direction that will sustain the innovation. To achieve this, leaders need to tolerate a certain level of chaos. This does not imply chaos will be destructive or cause problems but that difficulties arise for organisations that try to impose order on potential chaos rather than allowing a period of uncertainty.

Isaksen and Tidd (2006:148) argue traditional concepts of leadership are being influenced by new science - 'leading on the edge of chaos' and this links to the work of Stacey (1996:61) in that systematic thinking and leadership are human strategies that make it more possible for us to survive at the edge of chaos than other species. It is relevant here to reflect on the new form of leadership and note it requires a high degree of integration of working on the task and working with others. This study has set out to achieve that, acknowledging for the Prime worker innovation to survive, it requires not only strong leadership but also collaboration and cooperation. It also requires change to be embraced acknowledging innovation cannot work by opposing the change that is already happening and out of ones control.

Making a difference and sustaining innovation requires a high level of ownership from individuals and the organisation. Three characteristics of
ownership identified by Isaksen and Tidd (2006:162) are considered relevant in answering some of the research questions in this study (section 2.11, 3.3). The first is interest; that someone has the interest and motivation for the task and the organisation and wider stakeholders show interest and identify benefits to the innovation. The present system has strong leadership, led by the Named Nurse for the PCT (now Locality in nPCT). The data from this study provides confirmation of the advantages and importance in developing and sustaining the role by the PCT and wider stakeholders. The second is influence: making something happen. The PCT has significant power and influence in being able to provide the appropriate sanctions and validate the initiative and the wider stakeholders, the advocates - those who desire change but do not have the power to legitimise it but give support to sustain innovation. The third is imagination: The PCT is required under Section 11 of the Children Act to ensure systems are in place to safeguard and promote the welfare of children, but is also constrained by financial resources. The findings of this study acknowledge the benefits of the existing system which is free at the point of delivery and reaches 100% of GP Practices. Imagination is required in order to tolerate the degree of uncertainty in relation to the future direction of the role. These three characteristics comprise ownership and the findings from this study demonstrate the participants in this study have acknowledged and confirmed at the highest level within the organisation and other key stakeholders, that the innovation of Prime worker is appropriate, needed and supported. This is powerful evidence to support the continuation of and sustaining of the role in a period of uncertainty around the 'person to do the role'.

Equally, there are important links here to the NHS Leadership Qualities Framework (DH 2004f) that sets out standards for outstanding leadership in the NHS. Broadly considering the fifteen qualities identified within the framework to the PCT and Prime worker innovation (particularly the people within the organisation driving the innovation) with the findings from this
study has identified key qualities important in sustaining the innovation. These are:

- A drive for improvement and positive outcomes and links to the personal/emotional intelligence qualities needed by an organisation.
- Ability to set future direction by being flexible and anticipating the impact of change, gathering evidence and broad scanning of the wider issues and context.
- Seizing the future through developing a vision for future service development.

Key to the future success of the innovation is the ability to 'deliver the service identified' and this study has provided evidence of how the Prime worker innovation cannot work without collaborative working, effective strategic influencing, and leading through empowerment of those undertaking the role. Reflecting on the NHS Leadership Framework provides a useful tool to help understand the leadership challenges and to facilitate future direction in the development of the service. In the context of the NHS that is undergoing major cultural change provides a reflective framework to identify and to hold onto what is believed important within the organisation. An important link is made here to the literature reviewed in section 2.8.1, particularly Hart and Fletcher (1999) and Glennie (2003).

'Policy does not necessarily lead to change’ was a statement within the Q-sort that held some agreement across participants, citing 84/110. Policy should lead to change as that is the intention, but policy and procedures are no good unless there is a culture and climate conducive to sustaining and supporting change. The study has acknowledged the Prime worker initiative was initially launched across the county, but by 2005 only one PCT had the role functioning. In this PCT, the Prime worker role is embedded in the PCT child protection policy, and in 2005 following an audit (Smith 2005) protocols and standards were put in place and audited annually. The innovation had been 'kept alive' and sustained by strong leadership and support to practitioners in
a belief that the Prime worker system contributed to safeguarding and promoting the welfare of children within primary care, acknowledging the importance of bringing emotional intelligence into policy implementation. This study has highlighted the importance of leadership e.g. section 5.6.6, 5.6.8, and 5.6.9. Leadership requires sufficient attachment to political masters but also strong attachments to the needs of the service. The Government has put policy guidance in place to support the named/designated Dr and Nurse system but this study has questioned whether it is enough to safeguard and promote the welfare of children across the organisation in respect of its increased responsibilities and accountability? The author argues it is not enough and other requirements for safeguarding children require leaders to mediate between the politics of power and the politics of emotion, and be innovative to the wider requirements needed.

6.6.2 Emotional Intelligence¹ and Safeguarding Children

It is important to reflect on and consider how emotional intelligence can add value to the success of and sustaining innovation and to link the findings of the study with the literature reviewed relating to emotional Intelligence (section 2.9.1), particularly how the innovation is going to be sustained since the evidence provided in this study identifies that it should continue. Morrison (1997) identifies emotional intelligence as key to sustaining innovation and includes individual and organisational emotional intelligence as important.

Murphy (1997) acknowledges the emotiveness of working in child protection and importance to internal support networks, advocating staff care services should be an integral part of an organisation's child protection system, rather than an organisational reactive response as issues arise. He argues

¹ Emotional Intelligence facilitates individual adaptation and change and emotional capability increases the likelihood for organisations to realise radical change. At the organisational level, emotional capability refers to an organisation's ability to acknowledge, recognise, monitor, discriminate and attend to its member's emotions, and it is manifested in the organisational norms and routines related to feeling. These routines reflect organisational behaviours that either express or evoke certain specific emotional states (Huy 1999:325)
organisations need to acknowledge this an important and costly issue not just for staff within the organisation but also for the organisation.

Morrison (2006) supports this and emphasises emotional competence as a corporate issue for organisations not just simply a challenge for individuals and questions whether individuals at any level within an organisation can remain emotionally responsive and literate in an agency environment that is emotionally illiterate and unresponsive. The Prime worker network and regular meetings provide the emotional support to the existing Prime worker system, led by the PCT Named Nurse. It could be argued this has contributed to the 10 year success of the Prime worker role in the PCT being studied and this network acknowledged the importance of emotional capability that provides the Prime worker with the capacity for reorganising their own feelings and those of others for motivating members and for managing emotions (Smith 2005). It is proposed that the Prime worker role offers containment of emotions to staff within the PHCT.

An interesting finding from this study links to the literature reviewed in chapter 3. Hart and Fletcher (1999) gave importance to the environment that positively supports change, but change did not necessary require huge resources and finances. The findings reinforce and provide evidence that emotional capability represents a necessary antecedent for the success of and maintaining innovation and this is most likely to be achieved in an environment that positively supports change. More importance is given to the values not financial reward needed and this study has provided evidence to support this (section 5.6).

6.6.3 Audit and Monitoring.

In December 2006, the results of the annual Clinical Audit were published in relation to the existing Prime worker system (Harrison 2006) in the organisation being studied. The findings of this independent audit are useful
to discuss and provide further evidence and direction to corroborate the findings of the previous audits and this study.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Audit Findings (n=22 Practices)</th>
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<tbody>
<tr>
<td>1</td>
<td>Each GP practice/Primary Health Care Team (PHCT) will have a named Prime worker. (95%)</td>
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<tr>
<td>2</td>
<td>Each member of the PHCT will be able to identify who the Prime worker for Child Protection is. (91%)</td>
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<tr>
<td>3</td>
<td>Every member of the PHCT will be able to identify where the 'What To Do If ...' flow chart is located. (82%)</td>
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<tr>
<td>4</td>
<td>The Prime workers within the PHCT will receive training to the role and attend specific updates provided by the PCT Child Protection Team. (86%)</td>
</tr>
<tr>
<td>5</td>
<td>The Prime worker (or in absence, a health visitor colleague) will attend regular Practice meetings to disseminate information and update the PHCT regarding child protection. (82%)</td>
</tr>
<tr>
<td>6</td>
<td>When a new member of staff joins the PHCT (even temporarily), they will be given guidance on child protection within one week. (64%)</td>
</tr>
<tr>
<td>7</td>
<td>All Prime workers will attend 50% of the Prime workers meetings. (91%)</td>
</tr>
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Table 6.1 Results of an independent (not undertaken by the author) Annual Clinical Audit, published in December 2006.

The findings from the audit are positive in measuring the significance of the Prime worker role to safeguarding and promoting the welfare of children within a primary health care team setting. It fits into the PCT Clinical Governance arrangements and supports the evidence of this study the role should continue. A plan of action identified four recommendations from the audit outlined above. The document stated that by publication, two had already been implemented and were demonstrating strong leadership and commitment were driving the current system. Recommendations relate to ongoing training needs for Prime workers, updating the flow charts in line with recent procedural changes, Prime workers should ensure a representative attended meetings if they were unable to attend and a review of the letter given to all new PHCT members in relation to child protection arrangements.
6.6.4 Reflection on Benson’s Theoretical Perspective (4)

The PCT as an organisation has an important role in developing and maintaining the equilibrium required for the success of the Prime worker innovation. Equilibrium will be strengthened by a highly coordinated, interaction based system, high on consensus and mutual respect. To achieve and maintain this equilibrium, some realignment is required. Strong leadership needs to drive the innovation to prevent forced coordination, consensual inefficiencies or evaluation imbalances that would result in disequilibrium and failure of the innovation to achieve its set aims.

Benson (1975:231) acknowledges there is a deeper process that may also have influence on the success of innovation and relates to how the Prime worker innovation links to fulfilling the organisational objectives. By taking this into consideration, achievement of domain or ideological consensus, effective work cooperation and positive evaluation will be possible only to the extent it does not involve actions that undermine or threaten the interests of the organisation. It is important to acknowledge here the Prime worker role is integral within the PCT Child Protection Operational Policy of the PCT and the role actively supports the PCT in fulfilling the requirements of Section 11 of the 2004 Children Act.

In this climate of competing agendas, it may be difficult to get into organisational objectives and Benson draws attention to the power organisations have in the success of innovation and highlights the importance of leadership in getting ‘issues’ onto the agenda or into organisational objectives.
Summary points:

- The participants in this study have acknowledged and confirmed at the highest level within the organisation and other key stakeholders, that the innovation of Prime worker is appropriate, needed and supported.
- Sustaining innovation requires a high level of ownership from individuals and the organisation.
- The present system of Prime worker has been 'kept alive' and sustained by strong leadership and support to practitioners in the belief that the Prime worker system contributed to safeguarding and promoting the welfare of children. The role should be re-launched across the nPCT.
- The Prime worker system supports the PCT in meeting the requirements of Section 11 Children Act 2004.
- Evidence from Annual Clinical Audit in 2006 strengthens the importance and value to the organisation of supporting and maintaining the Prime worker role.
- The Prime worker system already exists with the people who have the skills and knowledge to undertake the role.
- How Child Protection systems are monitored within the PCT and GP practices needs clarity and needs to be made more visible at PCT Board level.
- The PCT should consider adopting the RCGP five-year strategy for supporting and strengthening GPs role in child protection. This development to juxtapose with the existing Prime worker system and work towards developing GPs with special interest in child protection.
- The Prime worker innovation needs to remain a PCT led innovation. The PCT maintaining the role, will provide a strong child protection link to GP practices and 100% coverage.
- The evidence suggests that policy and procedures are only effective if there is a culture and climate conducive to supporting and sustaining the changes required. The findings reinforce and provide evidence that emotional capability represents a necessary antecedent for the success of and maintaining innovation.

Figure 6.7. Summary points: The role of the organisation in maintaining the innovation.

6.7 'If it keeps child protection alive' – Safe Systems.

This section draws together future choices for the nPCT and is important in answering the research questions and for making recommendations.

6.7.1 The Prime Worker Model or GPs with Special Interests.

From the findings of this small study, it would appear there might not be a similar model to the phenomena of Prime worker as explored in this study. It does not mean there are not similar models out there, but it has not been
evidenced anecdotally through contacts with peers in neighbouring counties, literature explored or from the GP email discussion group.

The examples given from the email discussion group present different models from the Prime worker role and although examples of excellent practice, are more akin to the Named GP role as GPs with a special interest in child protection. The Prime worker role is not just about supporting GPs as evidenced by many of the email discussion group. It is supporting all primary health care team members within a GP Practice. Table 6.2 below considers and compares differences between the Prime worker and GPwSI roles.

<table>
<thead>
<tr>
<th>Prime Worker Model</th>
<th>GP with Special Interest Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaches 100% PHCTs.</td>
<td>Likely to be established in isolated GP practices. Cannot be imposed.</td>
</tr>
<tr>
<td>Free at the point of delivery.</td>
<td>Significant financial implications to the PCT if the role was established widely across GP practices.</td>
</tr>
<tr>
<td>100% are health visitor’s undertaking role (as at June 2007)</td>
<td>Relies on a GP having a special interest in child protection.</td>
</tr>
<tr>
<td>PCT led, supported and monitored through annual audit and reported to PCT Executive Committee.</td>
<td>Focus is mainly on supporting GPs and not on the whole primary health care team (although GPs are mainly their employers).</td>
</tr>
<tr>
<td>Acknowledged as ‘good practice’ in the County LSCB Child Protection and Safeguarding Procedures.</td>
<td>Supported by the RCGP five year Strategy ‘Keep Me Safe’ (2005).</td>
</tr>
<tr>
<td>Provides a system for collaborative child protection working between GP Practices and the PCT and provides an interface between primary and social care.</td>
<td>Provides a system for collaborative child protection working between GP practices and the PCT and provides an interface between primary and social care.</td>
</tr>
<tr>
<td>Prime worker role already established and can be built on.</td>
<td>Needs to be developed.</td>
</tr>
<tr>
<td>Protocol and Standards are in place.</td>
<td>Needs to be developed.</td>
</tr>
<tr>
<td>Strong leadership from Named Nurse and support networks already established.</td>
<td>Designated Dr / GP Tutor would be required to lead GPwSI and to support GPs.</td>
</tr>
<tr>
<td>Role needs to be formalised in job descriptions.</td>
<td>Models identified in the study were presented as ‘models of established good practice’ only within Individual Practices.</td>
</tr>
<tr>
<td>Credible evidence from this study to support continuation of a Prime worker role.</td>
<td>May be difficult to replicate and sustain across all GP practices.</td>
</tr>
<tr>
<td>There is the potential to monitor outcomes of the Prime worker role through combining QOF and Clinical Governance Monitoring for GP practices.</td>
<td>Need to consider risks to Primary Health Care Teams that do not have a GP with Special Interests.</td>
</tr>
</tbody>
</table>

Table 6.2. Comparison between Prime worker and GPwSI role.
Evidence has been provided as to the value of maintaining the existing Prime worker system. However, the PCT needs to give some consideration to developing GPs with Special Interest in Safeguarding Children alongside the existing Prime worker role. Whereas this study has confirmed previous evidence that the health visitor is considered best placed to be the Prime worker, a competing policy agenda appears to be distancing health visitors from primary health care team settings and longer term plans need to be considered. In other areas of the country, GPwSI have taken a pivotal role in leading the safeguarding agenda in primary care, yet as already discussed, this system is not in place within each GP practice but a GPwSI tends to cover a PCT or geographical area and cannot be compared to the ‘grass-roots’ level of the Prime worker system in each GP practice. Consideration as to why the GPwSI has not been developed widely may be due to financial constraints and this certainly must be a consideration in the long-term sustainability of the Prime worker role if the GPwSI was promoted widely across the nPCT to replace the existing system. Again, the author questions if the nPCT is ready to imminently move to a different model and reflects on the words of one Director ‘what is the evidence GPs are going to make a difference?’ This gives strength to maintaining the existing established system for the foreseeable future.

‘If it keeps child protection alive’ was a phrase stated on several occasions within the study in support of the Prime worker model. It was valued as a communication pathway and an effective way of offering first level support to all staff working within a PHCT. It was not perceived as ‘a job’ but likened to perhaps the NSF lead in a GP Practice. Perhaps consideration should be given to changing the title. Whatever direction the Prime worker role takes in the future, it is vital that it remains simple, realistic, achievable and sustainable and clearly any system that gives consideration to safeguarding children should be acknowledged and valued.
6.7.2 Summary reflection on Benson’s Theoretical Perspective (5).

Evidence from this study showed that other models explored do not equate to the ideology of the PCT led Prime worker model. Within the county and organisation being studied, there was equilibrium across domain consensus about how the role should be undertaken. None of the Q-sort or interview participants suggested another model might be more appropriate; in fact there was strong positive evaluation and ideological consensus that it would also achieve work coordination. The present system may require some realignment as already acknowledged, particularly the weakness or possible disequilibrium for the future sustainability of the health visitor being able to undertake the role (weakened domain consensus).

It is important to reflect on Benson’s perspective and to acknowledge if a change to the existing Prime worker system is to be considered, it is crucial the context into which change is introduced is known and appreciated by all stakeholders at the contemplation stage in order not to imbalance the equilibrium already established in domain and ideological consensus, positive evaluation and work coordination of the existing system. Only then is it possible to move successfully to a new direction or vision. If the PCT was to consider a different model for the future, significance must be given to work coordination (the practical arrangements) and financial implications. Links are made here to the chaos theoretical perspective and that in trying to establish new order; the potential risks and impact of destabilising the existing systems must be considered.

Summary points:

- From the findings of this study, there does not appear a similar model to the existing Prime worker system that reaches 100% GP practices and all PHCT staff.
- If thenPCT considers a different model to be more appropriate in the future, importance must be given to involving all stakeholders at contemplation stage in order not to imbalance the equilibrium already established.

Figure 6.8. 'If it keeps child protection alive' – Safe Systems.
6.8 Chaos or New Order?

At the outset of this study chaos was viewed as an interesting theoretical perspective in which to explore the existing Prime worker phenomenon. It was acknowledged child protection and the systems in place to protect children could never become linear and organised and may appear chaotic and certainly portrayed at times in the media as chaotic. Reflection is made here to Wheatley (1999) who reiterates that chaos and order exist as partners and chaos is a necessary process for the creation of new order and that stability is never guaranteed or desired.

The audits that provided the initial springboard to this study (Smith 2005) did not depict the system of Prime worker as truly chaotic but described a system of uncertainty and the system of Prime worker being sensitive to change in conditions or absence of conditions, and made recommendations to maintain but develop the role.

As this study has developed, the researcher is constantly reminded of the words of Gleik who offers a metaphor to explain the very nature of the inquiry into chaos (1987:24).

*It is like walking through a maze whose walls rearrange themselves with every step you take.*

The rate of change in the period in which this study has been undertaken is phenomenal (2004-2007) and it has been vital not to ignore the rearranging walls in the search for new order. Whilst the doctoral studies have been in progress, the service has been developed following audit recommendations (Smith 2005) and this has provided some new order to what appeared a chaotic system. Yet in some ways it may also appear more chaotic as driving and resisting forces have already questioned whether is it pulling apart or working together?
Undertaking this study has allowed the researcher to stand back and look at what is taking shape in the apparent confusion and see signs of new order developing over time, emerging with a stronger vision for future direction. This stronger vision and direction will be taken forward through the recommendations of this study. The original innovation identified 'attractors' (Gleik 1987) that pulled the innovation in a certain direction. This study has identified new kinds of 'attractors' that appear to be exerting force on the future direction of the Prime worker role. The evidence invites the question is it new order or have Government policy drivers appeared to make the sustainability of the role appear more chaotic? Any system can descend into chaos and unpredictability, yet within the state of chaos the system is held within boundaries that are well ordered and predictable (Legislation and Child Care Policy). Without the partnership of chaos and unpredictability, no change or progress is possible.

Wheatley (1999) draws on quantum physics and identifies four main factors as important to discovering order in a chaotic world, including the need for new ideas, new ways of seeing and new relationships to help work effectively in today's chaotic environment. Drawing on these factors to help understand the findings in relation to the phenomenon being studied, order can only be developed from within not imposed on the organisation or GPs for that matter. There needs to be a genuine commitment and 'sign-up'. The findings have identified that the organisation values the innovation of Prime worker. It is acknowledged chaos is a driving force that appears to be powerful and controlling, but also needs to be accepted as an essential process by which systems (including organisations) renew and revitalise themselves. Links are made here to Prigogine (1998) who demonstrated any open system has the capacity to respond to change and disorder by reorganising itself at a higher level of organisation. The initial perception of chaos within the Prime worker system should not be interpreted as a sign it should be discontinued but viewed as necessary for the creation of new order. This study has allowed reflection on the innovation; provided evidence to support its continuation.
and to reawaken creativity. In respect of relationships and information, it has identified the importance of effective communication and relationships in order to energise teams, work together effectively and is a vital factor in being able to safeguard and promote the welfare of children. Sharing information is the primary organising force in any organisation.

Links are made here to Edward Lorenz now famous ‘butterfly effect\(^2\) and Wheatley (1999) applies this to organisations. The butterfly effect of the apparent policy dissonance must be counteracted by strengthening the butterfly effect of good practice in relation to establishing systems for safeguarding children.

### 6.9 Original contribution to new knowledge.

It is believed undertaking this research provides an original contribution to knowledge. There is a wealth of literature on child protection, but a gap was identified in studies specific to primary care and of studies that have taken the recommendations of other research studies forward, particularly relating to the role of a lead child protection professional. Bannon et al (2003), Burton (1996) and Lupton et al (1999) all highlight recommendations that relate to the development of a lead child protection professional in primary care. This study has provided evidence how those recommendations have been interpreted and taken forward within practice and clinical teams. The Royal College of GPs strategy paper (Bastable 2005) reiterates that research into child protection issues in general practice is limited and reinforces Bannon et al’s (2003:49) comments on the ‘paucity of research around child protection and primary care’.

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\(^2\) Edward Lorenz, a meteorologist first drew public attention to the ‘butterfly effect’. Does the flap of a butterfly wing in Tokyo, Lorenz queried, affect a tornado in Texas (or a thunderstorm in New York)? In organisations, we frequently experience these ‘flaps’ when a casual comment at a meeting flies through the organisation, growing and mutating into a huge misunderstanding that requires enormous time and energy to resolve (Wheatley 1999:122-123).
Limited studies have been undertaken looking at child protection issues from an organisational rather than practitioner perspective (only Lupton et al 1999). It has sought the perspectives of the organisation and wider stakeholders and this was viewed important in the context of a move to an Integrated Service Delivery way of working. Unlike other studies, the PHCT has been the focus of this study, not just GPs role in safeguarding children (Bannon et al 1999, 2001, 2003, Burton 1996). Using existing knowledge and anecdotal evidence in a different way, generated new knowledge and understanding of the context and future direction of the phenomena studied.

In this study a Q-methodology approach was selected as the most appropriate method to uncover different patterns of thought and identify criteria important to clusters of individuals. It was a different approach to traditional qualitative studies but acknowledges the growing interest in Q-methodology for qualitative researchers and an atypical approach to 'hearing many voices'. This different approach generated new perspectives on how staff should be supported in primary care in relation to safeguarding children. The new knowledge identified at the macro (organisational and wider stakeholder) level in relation to the Prime worker role, adds to audits undertaken in 2005 at the micro level (PHCT).

The methodology need not be limited to the topic studied, as it could prove useful in any subject area as a powerful tool for systematically examining subjective data and to illuminate agreement and differences among individuals and group perceptions. The methodology selected allowed for different theoretical stances to be incorporated, particularly to capture and explore the confusion, contradictions and complexity of the Prime worker role though chaos theory and to maintain a link to theoretical perspectives used by other researchers (Lupton et al 2001), whose research developed recommendations to initiate a lead child protection professional within PHCTs. Other theoretical stances could have been adopted i.e. emotional labour has a lot to contribute and could be a direction for further study.
The intention in undertaking this study was to emerge with information necessary to make changes and develop stronger systems to safeguard children. In undertaking the precursory work to this study, it was acknowledged the theoretical paradigms adopted in the Policy Analysis and Service Development project although important, did not quite capture the confusion and complexity surrounding the Prime worker role and a new theoretical perspective emerged to juxtapose other paradigms in exploring and answering the questions of the research study – that of Chaos Theory as described by Wheatley (1999). This approach was appealing to the researcher and the decision to adopt triangulation of theoretical paradigms rather than a traditional constructivist approach was made. Chaos theory was also interesting for the researcher 'living the case experience' during the period under study.

Integrating the theoretical perspectives of chaos theory and Benson's model of Interorganisational Policy Analysis together was most appropriate and illuminating in helping to understand the findings and to the development of new knowledge. Using Benson's theory and comparing to Lupton et al's work (2001), it would seem nothing has changed. When chaos theory is considered – everything has changed. Chaos theory integrated into organisational theory has importance in that Benson's theory provided a theoretical link through all the work undertaken during the Doctoral programme. Exploration of the four dimensions of equilibrium identified by Benson offered a helpful framework to assist in understanding the findings of the study and the impact of external factors on the internal dynamics of a network. The network of Prime worker appears susceptible to changes from a national and local level. The four dimensions drew out the key issues to be addressed and what needs to be achieved if the Prime worker innovation is to be sustainable and equilibrium achieved. Chaos theory has been usefully applied to illuminate how the innovation being studied can emerge with a stronger vision for the future. It gave confidence to the future direction for the findings that chaos and order need to exist as partners and that the new order must come from within.
Chaos theory allowed understanding that without the partnership of chaos and unpredictability, any change or progress would be possible and the issues highlighted in using this framework indicated although susceptible to change, it did not indicate the role should be discontinued but rather some confusion and uncertainty are necessary for new order to emerge.

These theoretical approaches could be usefully applied to any organisational study, particularly exploring confusion and complexity around conflicting policy implementation (particularly multi-agency), or to help shape and understand a problem increasingly characterised as complex, inter-connected and rapidly changing.

Equally, using Benson's theoretical perspective allowed for 'containment' and understanding of the apparent presenting chaos and uncertainty of the Prime worker role during the in depth exploration of the study.

6.10 Relevance of research to Practice.

The Doctorate programme was developed to support clinicians in undertaking a higher level of research and to counteract any theory practice gap. In this study it has been important to provide evidence that links to the ideology of government policy and to the experience and delivery at the clinical level. This study has also provided the opportunity to become published research evidence rather than local grey literature.

This study has been undertaken during a period of prolific organisational change and emerging legislation and policy. At the commencement of study, the research was relevant to the one PCT being studied. In October 2006, there was reconfiguration of five PCTs in the county to become one nPCT. It is now more important to have evidence to propose the continuation of and expansion across the nPCT of the Prime worker role, rather than have a two-tier system across the county. Consequently, there is now a wider scope to
the study than originally intended, yet this is viewed as positive as the Prime worker role was originally launched across this county in 1997 as discussed in the introduction to the study.

The researcher acknowledges her own marked professional development during the period under study from being a health visitor with a special interest in child protection to Designated Nurse Safeguarding Children for the County. From this leadership role, the researcher is now in a position to lead, influence policy and practice and drive the child protection service towards better outcomes for children and to lead in taking forward the recommendations from this study within the nPCT and to wider stakeholders.

This study is a local organisational study and internal generalisability has importance. External generalisability has less importance as this is a study of a particular phenomenon and the findings are only generalisable within the County where the study was undertaken. However, results should provide the evidence to other Primary Care Trusts to take forward and develop their own strategic direction on supporting staff within primary care in relation to child protection issues as well as developing and sharing good practice and this will be considered in disseminating the findings.

Learning whilst doing allowed reflection in action and the researcher to question present practices and policy, shape future practice and influence future policy. The findings of this study have supported the literature explored to a great extent and have already influenced the development of County Child Protection Procedures in 2006 by providing justification to two other Local Safeguarding Children Boards who were not familiar with the Prime worker role, to support the inclusion of the statement: 'It is good practice to identify within the PHCT an identified professional who takes the lead role with regard to child protection concerns' (Section 9.10.33) in the new County Child Protection and Safeguarding Procedures. The findings are incorporated into the nPCT Internal Child Protection Procedures (2007) through inclusion of
the Prime worker protocol and standards. The role will be re-launched across all areas of the nPCT.

It has become apparent the process of undertaking this study has led to an increased awareness of the Prime worker role in the PCT at an organisational level and an increased awareness to wider stakeholders. Certainly, the Strategic Health Authority and Government Policy Officer were not aware of the role. The Government Policy Officer asked how the department would receive feedback on this study and expressed a wish to have a comprehensive report once the study was completed in order it could be considered in ‘influencing future policy’.

The process of undertaking the study and during the course of enquiry and data collection, it became apparent the process prompted various participants to question their own systems and what was in place for child protection (Respondent 4 & 6 and GP discussion group-ID) and the Lead Child Protection Director in the county acknowledged the Prime worker system was 'not in existence' any longer in her PCT area but stated it should be reviewed in the nPCT (Participant 1).

For the researcher, in a leadership role, striving to establish and sustain innovations in order to safeguard and promote the welfare of children within the Health Service, it is important to embrace rather than oppose change and reflect on and learn how to manage it. This study has allowed reflection and consideration to a new direction on the innovation being explored. From chaos to new order? – 2006 saw the removal of health visitors in one locality in the county (not PCT being studied) out of PHCT settings to geographical teams. Within six months, health visitors were returned to being GP attached and requested the researcher facilitate the re establishment of the Prime worker role in order to improve communication.

At the time of concluding this study, the role of Prime worker in the nPCT locality is going from strength to strength. There remains 100% allocation of
Prime workers and health visitors are still based in PHCT settings. The Prime worker network has strong leadership and commitment from Named Nurse who audited the standards in 2006 to provide further evidence of the value to maintaining, supporting and developing the Prime worker role.

6.10.1 Plan for dissemination of the findings.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Paper suitable for publication</td>
<td>October 2007</td>
</tr>
<tr>
<td>2 Executive summary of the Report to the PCT Board outlining recommendations.</td>
<td>January 2008</td>
</tr>
<tr>
<td>3 Executive summary of the Report to Local Safeguarding Children Board Executive Committee (wider stakeholders)</td>
<td>March 2008</td>
</tr>
<tr>
<td>4 Presentation to Prime Workers meeting.</td>
<td>January 2008</td>
</tr>
<tr>
<td>5 Enspiral – Half-day training days for Primary Health Care Teams.</td>
<td>Discuss future programme with GP Tutor</td>
</tr>
<tr>
<td>6 Consideration to presenting findings at the University of Surrey Research Conference 2008.</td>
<td>June 2008</td>
</tr>
<tr>
<td>7 Short article in PCT Newsletter</td>
<td>February 2008</td>
</tr>
<tr>
<td>8 Summary Report to Government Policy Department (not named to maintain confidentiality) and Royal College of General Practitioners.</td>
<td>February 2008</td>
</tr>
<tr>
<td>10 Presentation to National Safeguarding Children Association for Nurses (NSCAN) Conference.</td>
<td>2008</td>
</tr>
<tr>
<td>11 Royal College of Nursing 2008 International Nursing research Conference – Poster Presentation.</td>
<td>April 2008</td>
</tr>
</tbody>
</table>

Table 6.3. Plan for dissemination of the findings.

6.11 Conclusion

The direction for this study stemmed from the Policy Analysis and Service Development Project as precursors to this study and as part of the Doctoral programme. The Prime worker for child protection has been in existence within primary health care teams since 1997. The outcomes of the Policy Analysis and Audits strengthened anecdotal evidence of developing uncertainty around the value of the Prime worker role. This work made recommendations for a further study questioned the future direction of the Prime worker role from an organisational and wider stakeholder perspective.
This study set out to answer the research question of how staff should be supported in primary care in relation to safeguarding children. It has sought to gain an organisational perspective on the role and value of Prime Worker for Child Protection within Primary Care and to explore factors that are perceived as being important in relation to safeguarding children. This study has provided a comparison of the systems in place that support staff within Primary Care in relation to child protection and identified the best model for the PCT (at this current time). The key outcome of undertaking this research is the PCT will have a system in place that promotes and supports effective communication within primary care in relation to child protection.

The methodology selected allowed the apparent chaos of the Prime worker system to be explored in depth and to hear many voices through the development of the concourse and data collection techniques. It was acknowledged that in doing so, there was the possibility of destabilising the existing system in order for emerging patterns and the direction of new order. At the conclusion of the study, the evidence for continuing with the existing Prime worker system and who should undertake the role, may now appear even more chaotic than at the start of the study. The findings have been presented and analysed in order to try and make sense of and provide some future direction rather than solve a problem. The findings support and build on the literature reviewed. The interpretative approach to this study allowed different interpretations of what is perceived to be real, to be heard. It also allowed for in-depth perspectives on a particular phenomenon and for development of theoretical insights that offer possibilities rather than certainty for future directions and outcomes.

In concluding this study it is difficult to put a firm proposal as to what should happen next, as it must be achievable in the current climate of prolific change, PCT reconfiguration and future uncertainty of the health visitors' relationship to primary care. Who knows what future direction Integrated Service Development Programmes will hold and the long-term impact on the
primary health care team? What is certain is primary health care teams will continue to encounter families and children in need of support and it is vital staff are supported where children may be identified as at risk. Many references have been made to GPs, but this study set out to look at how all primary care staff should be supported in their role in safeguarding children.

From the themes emerging from this study, a number of building blocks that contribute to the facilitation of child protection have been identified. These include the importance of meta communication, the need for the PCT to support GPs in developing their role in safeguarding, the importance of the PCT leading innovation, a consensus as to the value of a lead professional for child protection within primary care and that safeguarding children is everyone’s responsibility. This study has also identified concerns about the perceived impact of competing government policy on child protection systems and networks.

This study has provided an evidence base to support the continuation of the present Prime worker system and that the health visitor at this current time is perceived integral and best placed to continue to undertake this role. The evidence does not imply someone else could not undertake the role (and this may need consideration in the future), but it is interesting to reflect that the GP (38/110) was rated lower than ‘anyone in the PHCT’ (57/110 - table 5.1) and at the outset of the Prime worker innovation, GPs refused to undertake the role. Presently, health visitors are firmly embedded within PHCTs and have a clear role at the interface between primary care and social care.

The principle of a Prime worker is well supported throughout the findings of this study; it is already established with protocols and standards in place, which provide a firm foundation for the future direction. The established system is free at the point of delivery, led and supported by the Named Nurse for the PCT Locality and evidence suggests that where it works well, the Prime worker can make a real difference to establishing safe systems in primary care for safeguarding children. It has also been acknowledged the
Prime worker role was 'not right yet' and recommendations will be made from this study in order to strengthen and raise the profile of the role and ensure those who take on the role feel valued and supported. The audit (Smith 2005) identified some dissonance between how Prime workers saw their role and the way others perceived and valued them. The study has provided evidence of the need to raise awareness of the role and a key recommendation is to relaunch the Prime worker role that gives a higher profile and awareness to the wider stakeholders than previous.

A clear directive from the literature and reinforced in this study for the future of the Prime worker is that ownership and professional leadership needs to come from within the PCT to sustain innovation. The PCT by supporting the role is going some way towards ensuring that PCTs safeguarding duties are fulfilled. The PCT can only put a system in place. It has also been identified in this study that GPs are self-employed and if the Prime worker system was not led by the PCT, it would be difficult to monitor, audit, set standards and provide support through regular Prime worker meetings. The Prime worker cannot be imposed but the sign-up could be strengthened across the nPCT through linking to the Quality Outcomes Framework and Clinical Governance arrangements monitored by the PCT. It is recognized each GP Practice is different and in some the Prime worker will be embraced and actively work to safeguard children, in others, it may not be so well received. However, the PCT should be made aware of these and it should be monitored.

It has been acknowledged the role is needed and valued and does not replace existing roles of Named Doctor / Nurse, but supports the structures providing a vital link between the PCT and Primary Care and vice versa. It would appear there might not be a similar model as explored in this study and no evidence of a similar role reaching 100% of GP Practices. The GPwSI role should be developed within the PCT parallel to existing systems to strengthen child protection in primary care. Whatever the future direction for the role, cost will always be a major consideration and if developing GPwSI as an alternative...
way forward, this has significant financial implications for the PCT to sustain, who may only be able to support 2-3 and therefore not reach 100% PHCTs.

The study acknowledged for those participants working in the PCT being studied, GPs appeared to be engaging more in child protection issues, but those working in other organisations outside the PCT being studied certainly did not perceive this. The PCT has some way to go yet towards engaging GPs in the child protection agenda, and this was evidenced by a lead Director who stated 'what is the evidence GPs are going to make a difference here?' A recommendation from this study is for the PCT to adopt the 2005 Royal College of GPs five-year strategy for safeguarding children. 'Keep me Safe' but needs to be monitored by the Designated Doctor.

In answering a key question of this study - is it chaos or new order? The answer is not clear. The PCT and wider stakeholders provided evidence of value to the role, that it should continue and it is universal to 100% PHCTs. Not clearly new order as the future direction as PCT is still amidst service redesign and the impact of Integrated Service Programme has not yet been identified. However, the climate and environment is right to introduce new order as the nPCT is established. The PCT by valuing and supporting the innovation of Prime worker for child protection within GP Practices helps the PCT create and maintain an organisational culture and ethos that reflects the importance of safeguarding and promoting the welfare of children.

To conclude this study, policy alone will not bring the changes required to safeguard children. Policy changes can be implemented at and from the top but silos may remain below. Every health professional is working towards best interests and outcomes for children and if we have not solved what was identified as important to change following the death of Victoria Climbie – then we have not changed at all. The findings of this study have found for the PCT being studied, at this present time, the Prime worker system helps put policy in place at grass roots level.

'If it keeps child protection alive'
6.11.1 Key findings of this study.

1. Safeguarding Children is everyone’s responsibility. This study provided evidence that this is being firmly embedded across all levels within the organisation being studied.

2. The existing Prime worker role provides a system for collaborative child protection working between GP practices and the PCT and provides an interface between primary care and social care.

3. The participants in this study have acknowledged and confirmed at the highest level within the organisation and other key stakeholders, that the innovation of Prime worker is appropriate, needed and supported. However, there is a need to raise awareness within the PCT and to wider stakeholders.

4. The evidence suggests that policy and procedures are only effective if there is a culture and climate conducive to supporting and sustaining the changes required. The findings reinforce and provide evidence that emotional capability represents a necessary antecedent for the success of and maintaining innovation. Support from the organisation and strong leadership were rated as important to sustain innovation and reach 100% of GP Practices, rather than having isolated pockets of good practice.

5. Communication with other agencies is still perceived as a problem in GP practices. Effective communication requires consideration to meta communication and importance is given to developing constructive relationships between individual members of staff supported by the organisation – communication with meaning.

6. The GMS Contract appeared important in the developing perceptions and strongly held views that GPs had to be paid to do anything.

7. The evidence suggests that competing policy agendas within government departments has impacted on proposals to increase child protection monitoring requirements of the nGMS Contract.

8. The Prime worker system already exists, free to the PCT at the point of delivery, with the people who have the skills and knowledge to undertake the role. The evidence suggests that competing government policy is a driver and resister impacting on the future of the Prime worker innovation.

Figure 6.9 Summary of the key findings from this study.
6.11.2 Recommendations

The key outcome from undertaking this research study is that the PCT will be able to adopt a system that promotes and supports effective communication within primary care, in relation to safeguarding and promoting the welfare of children. Concluding this study, recommendations are made with the intention that they will ultimately support the aim of better outcomes for all children.

Development of the researcher's own professional role during the period of this study, allows her to lead in taking forward these recommendations and to implement and monitor the action plan identified below. It is also acknowledged that in the precursory work leading to this study, recommendations were made in respect of developing the Prime worker role and these have already been implemented as identified through developing the protocol, standards and on-going audits.

### Recommendations for Practice:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>How this may be achieved</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The nPCT to support and develop the Prime worker role in all GP practices across the county.</td>
<td>Executive Summary Report &amp; presentation to the nPCT Board.</td>
<td>February 2008</td>
</tr>
<tr>
<td></td>
<td>Include development of the Prime worker role in the Annual Work Plan for Child Safeguarding.</td>
<td>May 2008</td>
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<tr>
<td></td>
<td>Presentation to the nPCT Child Protection Strategic Group.</td>
<td>April 2008</td>
</tr>
<tr>
<td></td>
<td>Researcher to lead the development of the Prime worker role across the County.</td>
<td>In progress</td>
</tr>
<tr>
<td>2. Annual auditing of the Prime worker Standards should continue within the Clinical Governance Framework of the nPCT and monitored by the PCT Safeguarding Group.</td>
<td>Annual audit will continue and a report will be provided to, and monitored by the nPCT Child Protection and Safeguarding Children Strategic Group.</td>
<td>Audit in progress Dec 2007 Annual Report due - May 2008</td>
</tr>
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<tr>
<td>3. The nPCT to re-launch the Prime worker role across the county.</td>
<td>Re-launch the role, facilitated by the nPCT Named Nurses &amp; Doctors.</td>
<td>In progress</td>
</tr>
<tr>
<td></td>
<td>Article for nPCT newsletter to raise awareness.</td>
<td>March 2008</td>
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<tr>
<td></td>
<td>Produce a leaflet to raise awareness of the role to primary health care teams.</td>
<td>April 2008</td>
</tr>
<tr>
<td>4. The nPCT to publicise the role of Prime worker to wider stakeholders through the Local Safeguarding Children Board.</td>
<td>Executive Summary Report to the Local Safeguarding Children Board and presentation to LSCB Executive Group.</td>
<td>April 2008</td>
</tr>
<tr>
<td></td>
<td>Produce a leaflet to raise awareness of the role to wider LSCB stakeholders.</td>
<td>April 2008</td>
</tr>
<tr>
<td>5. The nPCT Health Visiting Managers to formalise the role of Prime worker into job descriptions: 'You may be asked and would be expected to undertake the role of Prime worker for child protection within a GP Practice'.</td>
<td>Executive Summary Report &amp; presentation to the Health Visitor / School Nurse managers.</td>
<td>April 2008</td>
</tr>
<tr>
<td>6. The nPCT to consider developing the role of the GP with Special Interest in Safeguarding Children to support the existing Designated and Named Doctor, and the Prime worker role.</td>
<td>Arrange a meeting with the Chair of the nPCT Professional Executive Group (PEC), Designated Doctor and Lead Director for Safeguarding Children within the PCT.</td>
<td>In progress. Jan- Feb 2008</td>
</tr>
<tr>
<td>7. The nPCT to embrace the work of the Royal College of General Practitioners Child Protection Strategy, through the Designated Doctor, to raise the profile of child protection in primary care.</td>
<td>Arrange a meeting with the Chair of the nPCT Professional Executive Group (PEC), Designated Doctor and Lead Director for Safeguarding Children within the PCT.</td>
<td>In progress. Jan- Feb 2008</td>
</tr>
<tr>
<td>8. The nPCT to consider combining all GP practice inspections – PCT Clinical Governance, Contractual and Statutory requirements.</td>
<td>Arrange a meeting with the nPCT Primary Care Commissioning Team to discuss increasing child protection requirements of the Quality Outcomes Framework and combining GP Practice inspections. Support from the Chair of the nPCT Child Protection Strategic Forum to take this recommendation forward.</td>
<td>In progress Feb 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>January 2008</td>
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</table>
9. The Department of Health to continue to submit proposals for increased Child Protection and Safeguarding requirements in the Quality Outcomes Framework of the GMS Contract.

<table>
<thead>
<tr>
<th>Executive Summary Report to the Department of Health and Department for Children Schools and Families.</th>
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<td>February 2008</td>
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</table>

10. The Department of Health to consider a research study exploring the wider issues of competing policy drivers on safeguarding systems for children.

<table>
<thead>
<tr>
<th>Executive Summary Report to the Department of Health and Department for Children Schools and Families.</th>
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<tr>
<td>February 2008</td>
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</table>

Figure 6.10 Recommendations for Practice.

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**Recommendations for future areas of study:**

1. Poor knowledge of other people's roles may lead to presumptions and stereotyping and this may be an important area for further study.

2. Chaos theory has been used but this study identified that emotional labour has a lot to contribute and could be a direction for further study.

Figure 6.11 Recommendations for future areas of study.
REFERENCES


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Ramlo, S. Thompson, J. Kaut, K. (2006) Determining epistemological views among different groups of undergraduate students [online]. Q Methodology Network. Available from: [www.q-method@listserv.kent.edu](http://www.q-method@listserv.kent.edu) [Sent online 17th October 2006].


Sheffield Area Child Protection Committee (September 2005) *Serious Case Review in respect of (anonymised)*. Sheffield, Area Child Protection Committee. Executive Summary produced by Professor P. Cantril.


APPENDICES

Appendix 1  Summary of the Prime Worker Audit (2005)
Appendix 2  Prime Worker Protocol and Standards (2005)
Appendix 3  Letter to existing Prime workers inviting them to participate in a Focus Group
Appendix 4  Letter inviting to participate in Q-sort (similar adapted letter provided for Interview participants and GP discussion Group)
Appendix 5  Participant Consent Form
Appendix 6  Statements and source of statements used in Q-sort
Appendix 7  Q-sort – Conditions of Instruction
Appendix 8  Example of how data was recorded at a Q-sort
Appendix 9  Summary of on-line GP Discussion Group
Appendix 10 Time line for Research Study
Appendix 11 Time line of organisational changes, restructuring and relevant policy and legislation during the period under study
Audit of the role of Prime Worker for Child Protection within Primary Care for xx Primary Care Trust.

The purpose of this Report is to analyse the findings of the audit in relation to how this Service Development Project will benefit the Primary Care Trust (PCT) child protection systems and networks.

1. Rationale:

The role of Prime worker for Child Protection was introduced into the County of xx in 1997. This was following several Case Reviews that identified an urgent need to provide more effective support to GP surgeries across the County. This innovation was strengthened by research undertaken by Burton (1996) whose clear recommendations were "To identify a key child protection professional within the practice... to whom others will refer for information" (p46). The health visitor was thought to be the most appropriate person to undertake this role. Objectives were set for this role and disseminated to a nominated health visitor in each practice. It was anticipated that the Prime worker would develop and maintain effective communication systems within the Primary Health Care Team (PHCT).

Although this role was launched with some profile and local media coverage, locally it has never been formalised, evaluated or audited. The xx Area Child Protection Procedures (2000) are based on the Policy document 'Working Together (DH 1999) and state "Each GP practice will have a named Prime worker" (ACPC 2000 Section 8:13). Commitment to the principles of this role is embedded within the Child Protection Operational policy of the PCT. The PCT has a nominated Prime worker, therefore has reached 100% requirement as stated within the document. However, there are no Standards by which to measure this role.

In 2004, anecdotal evidence from practitioners undertaking this role, raised concerns and it appears that there is some confusion and developing uncertainty about this role. New staff into post have assumed the title of Prime worker without induction or training.
1.2 The aims of this project:
   - A Baseline Audit describing the role of the Prime worker as it is now, which can be used to set standards for the role of the Prime worker that can be measured.
   - To review the current system of Prime worker via the quality assurance cycle of monitoring, measuring and evaluating practice against a set of agreed criteria, in order to provide a high quality child protection service to families within xx PCT.

1.3 Guiding Principles: As embodied in the xx Child Protection Procedures.
   - The welfare of the child is paramount and children are entitled to protection from abuse, neglect and exploitation.
   - Each GP practice will have a named Prime worker for child protection.
   - Members of the Primary Health Care Team (PHCT) will work together constructively with personnel from different agencies.
   - All members of the PHCT will adhere to the xx Child Protection Procedures.
   - In child protection work the degree of confidentiality will be governed by the need to protect the child.
   - Members of the PHCT need to work openly and honestly with parents to achieve a maximum level of partnership and therefore better outcomes for the child.

2. Process:
   - Size of study and data collection: All 24 GP practices in the PCT. Two questionnaires:
     2. Random sample of other members of the Primary Health Care Team (N=80) to gain a perspective of the perceived role of the Prime worker.
   - Consent was obtained from the Director of Community and Intermediate Care in order to undertake this project and from the respondents through returned questionnaires.
   - Validity and reliability of the process was monitored and supported through the Clinical Audit Support Unit. The project will be reported through the Clinical Audit Team of the PCT. Recommendations of this project will also be disseminated through the Prime worker system and Annual Child Protection Report.
Anonymity and confidentiality of all participants was assured. It was not possible to trace any respondent back to any particular PHCT as this information was not requested or required.

The random sample of PHCT members were selected by sending each Practice Manager a letter and 3-4 envelopes containing the questionnaires. They were asked specifically to 'please can you give a letter to a GP' or Practice Nurse / Community Nurse / Counsellor / Clerical or Reception staff etc.

The letter to the Prime worker also outlined that members of the PHCT were being sent a questionnaire. This was to ensure that they were fully informed of the process and reassured that the results of the study could not be traced back to any particular team.

A questionnaire was deemed to be the most appropriate method to collect the baseline data required with a mix of open and closed questions. Using a questionnaire is an efficient method to reach the number of responses required. It also allows total anonymity of the respondent and hopefully more honest answers. Support of the Clinical Audit Support Unit ensured that the process was clear and systematic, well documented and provided safeguards against insider bias and misinterpretation of the results.

3. Results;

24 Questionnaires were sent to Prime workers. 19 were returned (86%)

80 Questionnaires were sent to members of the PHCT. 55 were returned (69%)

- Data was collated via an Excel spreadsheet, allowing data to be analysed by question number or individual's response. A summary data sheet was constructed that allowed an overview of the results, as this was not easily obtained via spreadsheet alone.
- The results from the two questionnaires remained separated until analysis. The summary data sheet was transferred onto the questionnaire and graphs inserted to facilitate viewing of the results.
- Draft Standards and a protocol have been written for the role of the Prime Worker using the data provided and with reference to the research undertaken by Burton (1996), existing Prime worker objectives and ACPC procedures. The key findings will be presented, discussed and debated with the existing Prime workers and ultimately written and sanctioned through the PW forum.

4. Analysis of findings.

The response rates of 86% for Prime workers (PW) and 69% for Primary Health Care Team (PHCT) questionnaires was very positive and reinforced the notion that this topic
should be explored and that issues relating to support networks for child protection were important and sought across the PCT.

The audit provided evidence that for some practitioners and PHCT’s the role of Prime worker is effective, working well and providing a system of communication and support relating to child protection and welfare issues within primary care. However, for others there is evidence that it is not (see results) and this is of concern as issues relating to poor communication at all levels has been a key recommendation from child death Inquiries spanning 30 years (Reder et al. 1993, DH 1995, Lupton et al. 2001, Laming 2003). The PCT has a responsibility to ensure systems are in place across the PCT (Smith 2002) and it cannot be in the best interests of children to have a two-tier or fragmented system.

A wide range of PHCT members and length of service was represented in the sample with 74% (n=41) of the sample aware of the existence of a PW with a good overall understanding of the role. However, it is a concern that 25% (n=14) had not heard of a PW and identified an urgent need to address this.

Evidence from the PW questionnaire demonstrated that 73% (n=14) of the nominated PW’s were senior experienced health visitors qualified for more than 10 years with 52% (n=10) being a PW since the role was established in 1997. It was surprising that although 68% (n=13) had received no training to the role of PW (and those that stated that they did, there was only actually an initial launch rather than formal training), and only 36% (n=7) had a copy of the objectives for PW that 68% (n=13) were clear or very clear about their role. However that left 31% (n=6) unsure or confused about the role. This was concerning as this number represented 25% of the total number of PW’s within the PCT. The risks here vastly increase regarding the breakdown of the systems in place since inception in 1997 for those PHCT’s where the PW is confused about their role, and the PHCT members unsure who to go to if they have a concern about the welfare of a child. It was not possible for reasons of anonymity and confidentiality to find and match this information to specific teams. However, the future development of the systems in place for child protection in Primary Care will be disseminated, implemented and reviewed across all PHCT’s within the PCT.
The PCT has a nominated PW for each PHCT (100%) therefore has met the requirement as stated in the Operational Policy, yet 84% (n=16) stated this role was not identified in their job description and 100% (n=19) stated that they did not receive any financial support or specific on-going training in order to undertake this role.

68% (n=13) of the PW's attend regular meetings within the PHCT, but it is a concern that 31% (n=6) did not and of those that did, not all had the opportunity to liaise and disseminate information relevant to child protection. These findings are also reflected in the PHCT questionnaire. A key objective of the role of PW at the outset was to facilitate and co-ordinate communication within the PHCT and this may prove difficult without attending PHCT meetings. This concern was reinforced by the findings from the PHCT members in that only 40% (n=22) had ever liaised with the PW on any aspect regarding the welfare of a child, although there was clear evidence that those members of the PHCT who had heard of the PW knew how to access him/her and 61% (n=34) stated that within the PHCT there was a system that enabled them to be aware of children who were causing concern or who were on the Child Protection Register.

Only 52% (n=10) of the PW's stated that they felt the role of PW was valued (see comments in results). This reflects the anecdotal evidence that was initially presented by the PW's. However, the PHCT had a good overall understanding of the role (see comments in results). It was surprising that 42% (n=8) would prefer someone else to undertake the role of PW, however 84% (n=16) stated the role should be continued and 78% (n=15) that the role should be developed. The comments made by the PW's throughout the questionnaire are very valuable (see results) and centre around training, recognition and support in order to undertake this role.

This baseline information will be taken forward and questioned in the larger study to be undertaken. However, overall these findings are not surprising but provide evidence that this role is identified as important and consideration should be given to formalising this role, re-launching it with policy and procedures to support it.

5. Recommendations:

5.1 An immediate response to the findings from these audits is to devise a framework protocol to the role of Prime worker and outline standards, which will be taken to the Prime worker group for discussion, debate and to
formalise into a final document. Involvement of the Prime workers in this process ensures inclusion and ownership to the ultimate decisions made.

5.2 Annual audit of the standards.

5.3 Raise an awareness of the role of Prime worker across the PCT through the child protection newsletter.

5.4 Training Needs Analysis.

5.5 To raise their profile, the Prime workers will be asked to facilitate the Commission for Health Improvement (CHI now CHAI) Audit that will be undertaken across the 24 PHCT’s looking at the child protection arrangements within these clinical teams.

5.6 An in depth research project using Q-methodology (phase 1) to gain insight at a strategic level into the ‘ownership’ of the role Prime worker through ranking existing perceptions of the value of this initiative and how it is perceived staff should be supported in practice in relation to child protection. Exploration (phase 2) of the systems in place within other PCT’s to support staff within Primary Care in relation to child protection.

6. Conclusion.

This project is just the beginning for service development exploring the role and value of practitioners working ‘at the coal face’ supporting, communicating and facilitating child protection. The ACPC Procedures and Child Protection Operational Policy of the PCT acknowledge the Prime worker as having a pivotal role. The audits provide evidence that at practitioner and PHCT level, there appears a general commitment to the role and value of the Prime worker and that this role should be continued and developed. The problems identified relate to clarity, support and training to the role.

References:


Anonymised PCT

PROTOCOL and STANDARDS

Prime Worker for Child Protection within Primary Health Care Teams.

This protocol has been formulated using the Prime Worker Objectives set in 1997 and from the results of the Baseline Audits undertaken in November 2004 – February 2005.

Aims

- Each GP Practice / Primary Health Care Team will have a key professional identified who will develop and maintain effective communication systems within the Primary Health Team (PHCT) relating to Child Protection.
- A support mechanism for Child Protection within PHCT’s will be provided.

(Section 8.4 of xx Child Protection Procedures)


1. The welfare of the child is paramount, and children are entitled to protection from abuse, neglect and exploitation.
2. Members of the Primary Health Care team will adhere to the xx Child Protection procedures.
3. Members of the Primary Health Care Team will work together constructively to protect children.
4. Members of the Primary Health Care team will disclose information on a need to know basis when they suspect that a child is 'in need', as well as where they suspect that a child is at risk of significant harm i.e. in need of protection.
5. Primary Health Care Team members will work in open and honest partnerships with parents and carers to achieve a maximum level of partnership and therefore a better outcome for the child.
6. There will be exceptions when it may be necessary to disclose information to Social services / Police prior to discussing concerns with the family i.e. Fabricated Illness, or where your personal safety is perceived to be at risk.

Responsibility for implementing and updating this Protocol is with the Named Nurse for Child Protection for xx PCT.
Protocol.

- **Scope**

  Every Primary Health Care Team (PHCT) within xx PCT will have a named Prime worker and every member of the team must be aware who is the Prime worker.

- **Nomination.**

  The Prime worker for Child Protection will be nominated from within the existing Health Visiting Team at the GP Practice, Medical or Health Centre. The Nurse Advisors for xx PCT will undertake this selection in negotiation with the Practice staff.

- **Child Protection advice to Primary Health Care Team.**

  The Prime worker will be required to give advice and support to any member of the PHCT who has concerns about a child. It is appropriate for the Prime worker to advise and mentor team colleagues but not to supervise. If at any time the Prime worker is unsure or the concerns appear complex, advice must be sought from a member of the PCT Child Protection Team.

  It is acknowledged through the Chief Nurses Report (2004) and the National Service Framework for Children, Young People and Maternity Services (2004), that practice nurses may need a more formalised system of mentoring. Prime Workers may undertake this formalised mentoring following specific training to this role (refer to Supervision Protocol). This training will be provided and the mentoring process monitored and supported by the PCT Child Protection Team.

- **Communication within the PHCT in relation to Child Protection.**

  - The Prime worker will co-ordinate the information flow within the Practice and encourage discussion within the Practice about Child Protection issues to promote sound planning.
  - Prime workers are encouraged to attend regular Primary Health Care Team meetings.
  - The Prime worker in respect of child protection issues will promote liaison between the PHCT and other agencies such as Social and Caring Service and Education.
  - The Prime worker will facilitate the PHCT to follow the xx Procedures in relation to preparation and attendance at child protection conferences.
  - The Prime worker will work to ensure that there is good preparation for, and that good quality reports are presented at Child Protection Conferences.
- The Prime worker will inform GP’s and other members of the PHCT (as appropriate) of the outcome of the Child Protection Conference.

- **The role of the School Nurse.**

Prime workers and school nurses need to develop an effective working relationship in order to share information and communicate issues and concerns relating to promoting the welfare of children within the Practice.

School nurse representatives will be invited to the Prime worker meetings.

- **Support for Prime workers in order to undertake this role.**

Management issues of Prime workers rest with the Nurse Advisors, who will support, advise and supervise the Prime workers. They will also update other agencies with any changes made to the role of Prime worker.

The Child Protection Team for the PCT will provide training specific to the role of Prime worker for Practitioners new to this role. A training needs analysis will be undertaken and reviewed annually.

Prime worker meetings will be held bi-monthly, facilitated by the Child Protection Team. These meetings will provide the forum to discuss and disseminate information relating to child protection Issues. The Prime workers meetings will also be the forum to advise and discuss issues relating to Child Protection Policy, Protocols and Procedures.

- **New staff coming into the PHCT.**

When a new member of staff joins the Primary Health Care Team (even temporarily), the Prime worker will ensure that they are made aware where the Child Protection Procedures and ‘What To Do If...’ flowcharts are located. This could be facilitated given written information / leaflet.

- **Monitoring.**

An annual Audit will be undertaken relating to the role of The Prime worker using the criteria identified overleaf.
## STANDARDS

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
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<tbody>
<tr>
<td>1. Each GP Practice / Primary Health Care Team (PHCT) will have a named Prime worker for Child Protection.</td>
<td>100%</td>
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<tr>
<td>2. Each member of the PHCT will be able to identify who the Prime worker for Child protection is.</td>
<td>100%</td>
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<tr>
<td>3. Every member of the PHCT will be able to identify where the 'What To Do If...' flow chart is located.</td>
<td>100%</td>
</tr>
<tr>
<td>4. All Prime workers within the PHCT will receive training to the role and attend specific updates provided by the PCT Child Protection Team.</td>
<td>100%</td>
</tr>
<tr>
<td>5. The Prime worker (or in absence, a Health Visitor colleague) will attend regular Practice meetings to disseminate information and update the PHCT regarding child protection.</td>
<td>80%</td>
</tr>
<tr>
<td>6. When a new member of staff joins the Primary Health care Team (even temporarily), they will be been given guidance on child protection within one week.</td>
<td>100%</td>
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<td>7. All Prime Workers will attend 50% of the Prime worker Meetings.</td>
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18th October 2005

Dear Prime Worker,

I am a student at the University of Surrey undertaking research as part of the programme. I would like to invite you to participate in a Focus Group at which lunch will be provided.

Title of research project:
How should staff be supported in Primary Care in relation to Safeguarding Children? Exploring the role, function and value of the Prime Worker for Child Protection within Primary Care from an organisational perspective.

Child protection is everyone's responsibility was a key message from Lord Laming following publication of the report in 2003 into the death of Victoria Climbie. Recommendations were made only too similar to those made in Inquiries spanning the last 30 years. However, for the first time organisations including health were highly criticised for what appeared 'widespread organisational malaise' (Laming 2003:4).

The death of Victoria occurred in a period of constant organisational change within the Health Service. A key theme in this study will be how organisations manage constant change yet also have effective systems in place that will provide support to staff and promote and safeguard the welfare of children. This study focuses on child protection support networks within Primary Care, particularly the role of the Prime worker for Child Protection. This research study takes forward some of the recommendations of the Prime worker audit undertaken in this PCT in 2004.

This study is being undertaken over two phases. This focus group is part of phase 1 which involves a Q-sort. A Q-sort can be likened to sorting a pack of cards and the aim of this focus group is to prepare these cards. As a group, you will be provided with a number of statements drawn from a literature search and data from the recent internal audits. You will be asked to look at the statements and to select the 50 -80 statements necessary for the Q-sort.

You are being invited to join this group because you represent a member of the Prime worker group and have focused specific knowledge and understanding of the role of prime worker / lead professional for child protection within primary care. Permission to approach you to participate has been obtained from the Head of Health Visiting and School Nursing.

Date: Tuesday 1st November  
Time: 1200-1330.  
Venue: Meeting room, -- House.

*If you would be interested and willing to participate, please complete and return the reply slip overleaf. THANK YOU. Lorraine Smith.  
Telephone: ...
Dear,

I am a student at the University of Surrey undertaking a Doctorate in Clinical Practice programme. I am undertaking a research project within this programme of study.

Title of research project:
*How should staff be supported within Primary Care in relation to Safeguarding Children? Exploring the role, function and value of the Prime Worker for Child Protection from an Organisational perspective.*

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

1. Purpose of the study.

"The extent of the failure to protect Victoria was lamentable. Tragically, it required nothing more than basic good practice being put into operation. This never happened". (Lord Laming 2003:6).

Child protection is everyone’s responsibility was a key message from Lord Laming following publication of the report in 2003 into the death of Victoria Climbie. Recommendations were made only too similar to those made in Inquiries spanning the last 30 years. However, for the first time organisations including health were highly criticised for what appeared ‘widespread organisational malaise’.

The death of Victoria occurred in a period of constant organisational change within the Health Service. A key theme in this study will be how organisations manage constant change yet also have effective systems in place that will provide support to staff and promote and safeguard the welfare of children. This study focuses on child protection support networks within primary care, particularly the role of the Prime worker for child protection. This research study takes forward some of the recommendations of the Prime worker audits undertaken in 2004.

The purpose of this study is to explore and try to understand what is happening in a specific context and to gain a perspective of organisational attitude and commitment to the role and value of Prime worker. This study is being undertaken over two

Letter inviting to participate in a Q-sort (similar adapted letter provided for Interview participants and GP online discussion group.)
phases between November 2005 and March 2006. Phase 1 involves a Q-sort and phase 2 involves semi-structured interviews. You are being asked to participate in a Q-sort. Q-methodology is a technique used to measure the relative position or ranking of an individual on a range of concepts. A Q-sort can be likened to sorting a pack of cards.

2. Why have I been chosen?
You are being approached to consider participating in this study because you have a key strategic role and influence on safeguarding children. The sample consists of approximately ten participants.

3. Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you decide not to participate or withdraw, you will not be contacted again.

4. What will happen to me if I take part?
A Q-sort involves sorting a series of statements. There is no right or wrong way to sort the cards. The researcher is interested in your own personal perception and viewpoint. The researcher will give you full instructions of the Q-sort process and answer any questions at the time of the Q-sort. Briefly, you will be given a set of cards to read in order to familiarise yourself with the statements. They will be presented to you in four separate sets. You will be asked to make three piles: statements you most agree with, least agree with and statements which you may be uncertain about.

You will then be asked to place the statements on a continuum ranging from -5 (least agree with) to +5 (most agree with), that most reflect your viewpoint. I will record on a grid where you have placed the cards. Once complete, you will be asked to sort another set of cards until all piles have been sorted. It is anticipated that the Q-sort process should take no longer than 45-60 minutes to complete.

If you agree to participate, I will arrange to meet with you at a day, time and venue that is convenient to you.

Following the Q-sort, I will give you the opportunity to debrief with a colleague or myself. The statements are not personal or sensitive.

The information collected from this meeting will be kept strictly confidential, stored securely during analysis and destroyed following completion of this project. Any data collected will be identified by numbers, not names in order to maintain anonymity to anyone other that myself as researcher. Excerpts and individual results from this meeting may be made part of the final research report, but under no circumstances will your name or any identifying characteristics be included in the report. The Primary Care Trust being studied will be identified only as 'A Primary Care Trust in the UK', however anonymity could be compromised even though every effort will be made to maintain anonymity. It is anticipated that the results of this study will be reported and disseminated through publication, conference and other presentations.

Letter inviting to participate in a Q-sort (similar adapted letter provided for Interview participants and GP online discussion group.
5. What are the benefits of participating in this study?
The key outcome of undertaking this research is that the PCT will have a system in place that promotes and supports effective communication within primary care in relation to safeguarding children. The results should also provide evidence to other Primary Care Trusts to take forward and develop their own strategic direction on supporting staff. I will ensure a summary report will be made available to you. You will not be identified in any way in the writing of these reports. This research is being undertaken as part of a Doctorate in Clinical Practice programme at the University of Surrey and is due to be completed in December 2007.

6. Who has reviewed the study?
This study has been reviewed and is being monitored by Professor Helen Cowie and Dr. Pat Colliety at the University of Surrey. The Research Ethics Committee and Sussex Research Consortium have also reviewed the study.

7. Contact for further information.
Lorraine Smith
C/o ..... 
Level 5 
Duke of Kent Building 
EIHMS 
University of Surrey 
Guildford 
(... L.Smith mobile)

Thank you for taking the time to read this and giving consideration to participating in this study.
CONSENT FORM

Title of Project:
How should staff be supported within Primary Care in relation to Safeguarding Children? Exploring the role, function and value of the Prime Worker for Child Protection.

Name of Researcher: Lorraine Smith.

Please initial box

1. I confirm that I have read and understand the information sheet dated ....................... (version 2) for the above study and have had the opportunity to ask questions. □

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. □

3. I agree to the use of any of my comments (anonymised) as part of the final research report. □

4. I give consent for audio taping of this meeting. □

5. I agree to take part in the above study. □

Name of Participant  Signature  Date
Lorraine Smith

Researcher  Signature  Date

1 copy for participant; 1 copy for researcher
<table>
<thead>
<tr>
<th>Statement number</th>
<th>SOURCE of STATEMENTS used in the Q-sort.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. More effective child protection systems are needed in general practice (DH2004d:6).</td>
<td></td>
</tr>
<tr>
<td>2. GPs often devolve to health visitors the responsibility for decision-making about referrals to social services (Lupton et al. 1999:6).</td>
<td></td>
</tr>
<tr>
<td>3. Members of the primary health care team will continually encounter children in need of protection (Carter et al. 2003:26).</td>
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<tr>
<td>4. Practitioners at all levels should be supported in their role of protecting children (Audit-Smith 2005).</td>
<td></td>
</tr>
<tr>
<td>5. It is important that all members of the PHCT are aware of vulnerable children and families (Audit-Smith 2005).</td>
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<tr>
<td>6. Policy does not necessarily lead to change (Glennie 2003:176).</td>
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</tr>
<tr>
<td>7. A support network for child protection within primary care teams is essential (Audit-Smith 2005).</td>
<td></td>
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<tr>
<td>8. The role of Prime worker for child protection within primary care has implications on an already high workload (Audit-Smith 2005).</td>
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</tr>
<tr>
<td>10. The key child protection professional for each PHCT may need training, protected time and support in order to undertake this role (Burton 1996:46).</td>
<td></td>
</tr>
<tr>
<td>11. Each GP Practice must have a lead child protection professional (Carter et al. 2002:26).</td>
<td></td>
</tr>
<tr>
<td>12. Achieving high-quality services that help give children the best start in life rests with those who work with children and families on a daily basis (DH 2004e).</td>
<td></td>
</tr>
<tr>
<td>13. What is needed is for Trusts to commission child protection as a service in which GPs are given the time and money to prioritise it (Children Now 2-8 Feb 2005:20).</td>
<td></td>
</tr>
<tr>
<td>14. What is needed is for Trusts to commission child protection as a service that GPs can opt into (Children Now 2-8 Feb 2005:20).</td>
<td></td>
</tr>
<tr>
<td>15. All those working in the field of health have a commitment to protect children (ACPC Procedures Section 8.4).</td>
<td></td>
</tr>
<tr>
<td>16. Those who occupy senior positions must be required to account for any failure to protect vulnerable children from deliberate harm or exploitation (Laming 2003:6).</td>
<td></td>
</tr>
<tr>
<td>17. Health Professionals may be the first to detect that a child is at risk, and the consequences of them failing in this recognition can be dire (Carter and Bannon 2003, Chapter 3).</td>
<td></td>
</tr>
<tr>
<td>18. Understanding the ideas that underpin policy is essential if staff are to appreciate the context in which they work (Hannigan and Burnard 2000:519).</td>
<td></td>
</tr>
<tr>
<td>19. The key child protection professional for each PHCT needs financial incentive in order to undertake this role (Burton 1996:45).</td>
<td></td>
</tr>
<tr>
<td>20. Enhanced roles undertaken by staff should be clearly defined in their job description (Fraher 2001:81).</td>
<td></td>
</tr>
<tr>
<td>21. It is at the frontline that investment and effort must be concentrated in relation to keeping children safe (Children Now 22-28 June 2005:10).</td>
<td></td>
</tr>
<tr>
<td>22. Child abuse and neglect is one of the most serious health conditions affecting children... it should be looked at as any life threatening illness (Bastable 2005a:167).</td>
<td></td>
</tr>
<tr>
<td>23. GPs work arrangements are a world apart from anyone else’s. Local primary care trusts commission GPs to carry out specific services and, consequently, GPs run their surgeries like small businesses (Children Now 2-8 Feb 2005:15).</td>
<td></td>
</tr>
<tr>
<td>24. Initiatives need to be supported by ‘the organisation’ if they are to succeed (Audit-Smith 2005).</td>
<td></td>
</tr>
<tr>
<td>25. Primary Health Care Teams should identify a key child protection professional within the practice to whom others will refer for information (Burton 1996:46).</td>
<td></td>
</tr>
<tr>
<td>26. If health visitors were separated from primary health care teams this could result in communication breakdown (Children Now 22-28 June 2005:10).</td>
<td></td>
</tr>
<tr>
<td>27. Within the PHCT, staff come to the health visitor with their child protection concerns (Audit-Smith 2005).</td>
<td></td>
</tr>
<tr>
<td>28. The role of Prime worker for child protection is not needed, as communication is already very good in primary care (Fraher 2001:89).</td>
<td></td>
</tr>
<tr>
<td>29. Although practice nurses have high levels of interaction with children, they are frequently unaware of vulnerable children (Focus Group).</td>
<td></td>
</tr>
<tr>
<td>30. Systems are in place to alert GPs how many vulnerable children there are in their Practice (Focus Group).</td>
<td></td>
</tr>
<tr>
<td>31. The climate of constant change within the National Health Service has appeared to destabilise local child protection networks (Lupton et al. 1999:105).</td>
<td></td>
</tr>
<tr>
<td>32. Communication with other agencies is not a problem in GP Practices (Audit-Smith 2005).</td>
<td></td>
</tr>
</tbody>
</table>
34. There is a risk of becoming too 'strategic' and distancing senior staff from the day-to-day realities (Laming 2003).

35. The Prime worker for child protection should be someone the GPs will liaise with (Audit-Smith 2005).

36. Regular discussions of vulnerable families within a PHCT can help professionals provide early support to vulnerable families (Poblete 2003:6).

37. There is a risk that during organisational change, children may be less safeguarded than previously (Lupton et al 2001).

38. Communication between staff in the same and different agencies is of paramount importance to ensuring the protection of children (ACPC Procedures Section 8.4).

39. Legislation alone will not improve communication or increase collaboration (Kenny 2002:35).

40. Effective communication relating to child protection is important at the interface of general practice (Burton 1996:5).

41. Poor communication has been a significant factor in the historical failure to protect children from abuse and neglect (Lupton et al 1999).

42. There are clearly aspects of the political and social context that work against effective communication and co-operation, such as frequent organisational change (Bannon 1996:79).

43. A supportive network should be established at the 'grass-roots' level where child protection issues and concerns can be identified at the earliest opportunities in a proactive and preventative way (Poblete 2003:Chapter 1).

44. The role of the Prime worker for child protection is not clearly understood (Audit-Smith 2005).

45. The health visitor is the most appropriate person to be the Prime worker for child protection within primary care (Fraher 2001, Audit-Smith 2005).

47. Health visitors have a high degree of involvement in child protection matters (Lupton et al 1999, Executive Summary:2).

48. The role of the Prime worker should be undertaken through good will and commitment rather than any reward (Audit-Smith 2005).

49. In GP Practice, child protection is the responsibility of health visitors (Audit – Smith 2005).

50. Health visitors are seen as the professional group within health that is clearest about its own professional role in protecting children (Lupton et al 1999, Executive Summary:4).

51. A child protection lead professional in GP Practice has a role in coordinating training needs of all Practice staff (PCT Prime Worker Protocol 2005).

52. The role of lead child protection professional in primary health care teams should be continued (Audit – Smith 2005).

53. GPs are expected to contribute to a process for which they perceive themselves as having little time, experience or appropriate training (Burton 1996:5, Lupton et al 1999:13 Executive Summary Report).

54. The organization already has enough child protection specialists; therefore the role of prime worker for child protection within primary care is not required (Fraher 2001:81).

55. A child protection lead professional in GP Practice should be a GP (Researcher).

56. Any member of the PHCT could undertake the role of Prime Worker for child protection (Audit – Smith 2005).

57. The role of Prime worker for child protection within primary Care is an informal arrangement whereby one of the health visitors takes on that role (Fraher 2001:81).


59. Because of the universal nature of health provision, health professionals are often the first to be aware that families are experiencing difficulties in looking after their children (Poblete 2003:6).

60. Within the primary care team the person with the most interest in child protection is not necessarily always the health visitor (Audit – Smith 2005).

61. GPs are the professional group most unclear about the role of others within the child protection process (Lupton et al 1999, Executive Summary:2).

62. A more active role for a lead child protection professional is required in GP Practice (Burton 1996).

63. GPs are the professional group most unclear about its role in child protection (Lupton et al 1999, Executive Summary:2).

64. Health visitors have extensive training in child protection (Burton 1996).

65. GPs are on the periphery of the child protection system and uncertain of what is expected of them (Burton 1996:4).

66. More time should be given to the role of the lead professional for child protection within GP Practices so that the Job can be done properly (Audit – Smith 2005).

67. The Prime workers for child protection is valued, they are talked about, and their profile is high (Fraher 2001:26).
68. The PCT already have child protection specialists, therefore the role of Prime worker for child protection within primary care is not needed (Fraher 2001:90).

69. If you do not have a PHCT working cohesively and working together, then this is where vital information is lost (Bannon and Carter 2003).

70. Meeting regularly enables all the professionals involved with children to have regular and easy communication (Children Now 23 Feb – 1st March 2005:20).

71. It is important that other agencies are aware that there is a lead professional in general practice that they can liaise with about child protection concerns (Focus Group).

72. Health visitors should always be attached to GP practices (Children Now 22-28 June 2005:10).

73. Meeting regularly and sharing information face-to-face there is a much stronger element of trust in relation to discussing child protection concerns (Children Now 23 Feb – 1st March 2005:20).

74. The health visitor's role is very much in the PHCT working alongside the GPs and other members of the team (Prime Worker Objectives 1997).

75. The cumulative pressures of constant change in the health service have adversely affected the capacity of certain health professionals to take a participatory role in child protection (Lupton et al 1999:105).

76. Child protection concerns could be missed if health visitors were separated from primary health care teams (Children Now 22-28 June 2005:10).

77. On-going structural change in the NHS is seen as particularly problematic in fracturing the health service (Lupton et al 1999, Executive Summary: 11).

78. The families at greatest risk are those outside the child protection system (Researcher).

79. One of the problems for GPs working in child protection is accessing training (Lupton et al 2001).

80. Failure to implement collaborative working has led to the fragmentation of care and can lead to poor outcomes Lupton et al 1999:114).

81. Actually in my role, we don't do child protection (Focus Group).

82. Since the introduction of the GMS Contract, GPs are more likely to prioritise other services above those focused on children (Children Now 2-8th March 2005: 10).

83. Paying GPs to take child protection into account will confirm many of the suspicions that frontline practitioners have about doctors' attitudes towards child protection ranging from disinterest to outright obstruction (Children Now 2-8th March 2005: 15).

84. The National Service Framework for Children minimum requirement of every trust appointing a children's lead will draw GPs out of their silos (Children Now 23 Feb – 1st March 2005:21).

85. GPs rely on health visitors to provide information on the social situation of the child / family in order to assess risk (Lupton et al 1999:95).

86. The vehicle the Government has chosen for encouraging GP's to work more closely with children's services is the National Service Framework for Children, Young People and Maternity Services (Children Now 23 Feb – 1st March 2005:21).

87. Ask most children's professionals what they really think of GPs and child protection and they'll describe a 'reluctant partner' (Children Now 23 Feb – 1st March 2005:20).

NB 21A and 46R removed 26.11.2005 prior to pilot as repetitive.
Q-sort Conditions of Instruction.

Title: **How should staff be supported in primary care in relation to safeguarding children?**

There is no right or wrong way to sort the cards. I am interested in your own personal opinion.

There are four sets of cards.

I will give you one set of cards at a time and ask you to sort the cards into 3 separate piles:

- The right hand pile for those that you most agree with.
- The left hand pile for those that you least agree with.
- The middle pile for those that you are uncertain about.

In front of you, there is a numbered continuum ranging from -5 (least agree with) to +5 (most agree with). Starting with the 'right hand, most agree with pile', please place the cards, in descending lines below the number on the continuum that most reflect your viewpoint.

Once completed, please take a brief moment to review where you have placed the cards and move any should you so wish. You may find it easier if you review the cards from right to left.

Please feel free to make any comments as you sort the cards or at the end about any of the statements on the cards.

I will record each sort as you move onto the next set of cards. You will be asked to sort another set of cards until all four sets have been sorted.

THANK YOU.
### EXAMPLE OF HOW DATA WAS RECORDED AT TIME OF THE Q-SORT

**Record sheet.**

<table>
<thead>
<tr>
<th>Most disagree</th>
<th>Most agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>-5</td>
<td>-4</td>
</tr>
<tr>
<td>13A</td>
<td>11A</td>
</tr>
<tr>
<td>14A</td>
<td>12A</td>
</tr>
<tr>
<td>19A</td>
<td>16A</td>
</tr>
<tr>
<td>22A</td>
<td>20A</td>
</tr>
<tr>
<td>31C</td>
<td>29C</td>
</tr>
<tr>
<td>32C</td>
<td>34C</td>
</tr>
<tr>
<td>33C</td>
<td>43C</td>
</tr>
<tr>
<td>37C</td>
<td>40C</td>
</tr>
<tr>
<td>42C</td>
<td>41C</td>
</tr>
<tr>
<td>49R</td>
<td>45R</td>
</tr>
<tr>
<td>55R</td>
<td>57R</td>
</tr>
<tr>
<td>60R</td>
<td>48R</td>
</tr>
<tr>
<td>67R</td>
<td>52R</td>
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<tr>
<td>54R</td>
<td>65R</td>
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<tr>
<td>56R</td>
<td>68R</td>
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<td>66R</td>
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<tr>
<td>75W</td>
<td>79W</td>
</tr>
<tr>
<td>76W</td>
<td>81W</td>
</tr>
<tr>
<td>77W</td>
<td>87W</td>
</tr>
</tbody>
</table>

Comments: Continue overleaf...
Summary of on-line GP Discussion. Appendix 9

The discussions generated an exchange of views about:

**General issues.**

- Child protection training should be mandatory for all employees and employers – 'no one should be too busy or insufficiently interested to attend' (SP).
- Time must be made available and provision for cover.
- The increasing amount of clerical work required by GPs on top of clinical.
- The profile of Child Protection Conferences must be raised for GPs – to give them the opportunity to attend and the opportunity to write reports in a manageable time frame.
- Training should be targeted ... for the whole Practice and to GPs directly.
- Funding – 'In terms of threats to this (Named GP system) money is the issue and persuading those with purse strings that they really do have to spend money even when things are tight is an on-going battle' (ID)

**Effective Child Protection systems.**

Several GPs identified examples of effective child protection systems in their own Practice.

*We try to be sure the advice pathway is known i.e. who is the named person for the Practice is ... referral route and information sharing, the latter point is probably critical.* (ID)

*I am part of a very supportive and active child protection team in B (named city) where the meetings are well attended and the tasks set are done ... as Named GP I feel my role is valued and recognised, being paid appropriately and the work being flexible to meet whatever the demands are (SP).*

*The collected five Named GPs in ... have evolved a set of evening lectures for GPs and anyone who wishes to attend ... the Named Nurse and I have put together a session that can be delivered to a whole Practice.* (ID)

**The person to lead.**

All GPs were the lead in their Practice. One GP commented 'the health visitor and two GPs (should be the lead).

*We are currently feeling very anxious that our health visitor's will be cut and will be doing a lot more fire fighting' than previous work* (SP)

*I think a GP is likely to be best placed to offer local advice within a Practice* (ID)
The Quality Outcome Framework (QOF).

One GP asked if PCTs were asking GPs to show how they are complying with their contractual obligations (No 20 of nGMS Contract) – 'individual healthcare professionals ... should be able to demonstrate that they comply with national child protection guidance (JM).

Responses included that the 'PCT only asked Practices to show them where the ACPC/LSCB guidance was kept (MW). The same GP wrote to the Medical Director / Clinical Governance Lead of the PCT requesting they looked more systematically for evidence (e.g. significant events reviews and whether reports for Conferences were completed) but he did not receive a response.

Another GP commented that 'following the previous round of QOF requirements, two of the four RCGP submissions for the nGMS Contract were child protection but they were rejected because of lack of evidence base (RB). (NB This was also highlighted as an issue in Interview 2).

A GP informed the group of a pilot in his PCT where 'all inspections were being combined into 1 – QOF, contractual, statutory and PCT clinical governance targets'. He highlighted the initial difficulties for child protection had been clarity was needed between the QOF, clinical governance requirements etc (HC).

A GP questioned 'is it not a PCTs responsibility to check that GPs are complying with the Core part of the GMS Contract? This is not part of the QOF but a contractual requirement and we have all signed that contract with the PCT (KL). These comments also reflect a question posed at Interview 2 and an area for further exploration. Comments from colleagues were 'I would agree but QOF seems to be the bit of the Contract most closely monitored, especially now PCTs are bogged down in the core business of NHS structural reorganization again (MW). He posed a question 'how often does your trust visit outside of the quality / compliance visit? ... they don't seem to in ... (named Trust).
TIMETABLE

Policy Analysis
Service Development
Literature Search
Proposal
Ethics Committees
Data Collection

Service Development
Literature Search
Proposal
Ethics Committees
Pilot
Data Collection

Time line for research study

Appendix 10
Appendix 11

Time line of organisational changes / restructuring and relevant Policy and Legislation implementation 2002-2007

Apr-02 Primary Care Groups became Primary Care Trusts.
Apr-03 GPs with Special Interests in the Delivery of Clinical Services: Child Protection (DH).
May-03 Every Child Matters Green Paper (DfES).
Aug-03 XX Children's Trust Pilot commenced.
Mar-04 Every Child Matters: Next Steps (DfES).
Mar-04 Changing role – Acting Named Nurse Child Protection / Lecturer Practitioner
Apr-04 GMS Contract.
Apr-04 Quality Outcomes Framework introduced into General Practice.
The Chief Nursing Officer’s review of the nursing, midwifery and health visiting contribution to
Aug-04 vulnerable children.
Sep-04 National Service Framework for Children, Young People & Maternity Services (DH).
Oct-04 National Service Framework for Children … Key Issues for Primary Care (DH).
Nov-04 Choosing Health: Making healthy choices easier (DH)
Dec-04 Every Child Matters: Change for Children in Health services (DH).
Mar-05 Common Assessment Framework Published (DfES)
Mar-05 Changing role – Named Nurse Nurse Crýiýd Pmteý-*; -n ý' 1
Aug-05 Cross Government Guidance - Sharing information on Children and Young People (DfES) - Draft.
Aug-05 Working Together to Safeguard Children (DH) - Draft.
Aug-05 Information Sharing Protocol 2006 - XX Children’s Trust (anonymised)
Sep-05 D.Clin. Prac. - Ethics Committee and R&D. submission and approval
Sep-05 Changing role – Consultant Nurse Safeguarding Children / Designated Nurse for County.
Nov-05 Submission to University Ethics Committee and Social Services Ethics Committee.
Nov-05 Focus Group.
Nov-05 Pilot of Q-sort (4).
Dec-05 Data collection commenced.
Jan-06 New GMS Contract 2006/7
Apr-06 Information Sharing Protocol 2006 (DfES).
Apr-06 Area Child Protection Committee became Local Safeguarding Children Board.
Apr-06 Social Care / Education re-organisation and Integration – Children and Young People's Service.
Jul-06 Strategic Health Authority re-structuring.
Dec-06 Primary Care Trust Reconfiguration - Five Primary Care Trusts in County to one nPCT.
Mar-07 Commissioning framework for health and well-being (DH)
Apr-07 Revised Section 11 Children Act 2004.
Jun-07 Consultation Paper on PCT reconfiguration of Health Visiting.

Title:

Avoiding the Politics in Child Protection Research

September 2007
Abstract

Undertaking research within an organisation can be problematic and further compounded if the topic being studied is emotive and heavily framed in policy and legislation. The aim of this paper is to share the author’s experience of using a modified approach to Q-methodology and proposes this as a useful and reliable method for liberating opinion in a politically charged area where senior staff may be reluctant to express personal viewpoints and subjective opinion.

Key words

Q-methodology, Q-sort, qualitative research, child protection, primary care

Introduction

Q-methodology has proven ability and validity as a method to elicit genuine subjective opinions and perceptions for use in researching politically constrained subject areas. Child protection is an emotive topic and in itself may cause difficulties when contemplating research. These difficulties may be exacerbated if the researcher holds a senior position within an organisation and seeks to gain an emic perspective from other senior members of staff who are influential stakeholders in the phenomenon being studied.

In considering the most appropriate methodology, a variety of qualitative approaches were considered. The study sought to gain individual viewpoints and perspective, and the researcher was concerned that a more traditional approach to qualitative data collection focusing on interviews would produce a regurgitation of policy from the senior members of staff being asked to participate in the study.
Context for the study

The extent of the failure to protect Victoria was lamentable. Tragically, it required nothing more than basic good practice being put into operation. This never happened. (Lord Laming 2003:5).

Q-methodology was utilised to explore this potentially emotive topic which is of critical importance, as the Inquiry into the death of Victoria Climbie criticised organisations for what appeared 'widespread organisational malaise' in respect of safeguarding children (Laming 2003:4). The study took place in a Primary Care Trust (PCT) in the UK (2005-2006), within a context of prolific organisational, structural and policy changes. In October 2006, the PCT reconfigured with four other PCT's. The findings of the research have become more significant to the resultant singular PCT in providing future direction to the child protection service. The study focused on child protection support networks within primary care, exploring the role and value of the existing lead professional for child protection in GP Practices. The trigger for the study stemmed from the findings of two audits that questioned organisational commitment to maintaining the lead professional role. The study sought to gain perspectives from senior members within the PCT and from wider stakeholders who had a key strategic role and influence on child protection. The key outcome of undertaking this research was to inform the PCT on a model that promoted effective communication within primary care in relation to safeguarding children. It was acknowledged that in order to achieve this, innovation needed to be supported and valued by the organisation and evidence was required to accomplish this and give future direction.
Q-Methodology

Q-methodology is a technique used to measure the relative position or ranking of an individual’s views on a range of concepts. It was first described by Stephenson in 1936 who drew the letter ‘Q’ to represent the methodology and conceptual framework associated with the study of subjectivity. This methodology is fairly well known in quantitative research and is gaining credibility and notoriety amongst qualitative researchers (Brown 1991, 1996, Mercer 2006, Stenner et al 2007). In selecting this methodology, the researcher was drawn to the work of Brown (1996) who proposed Q-methodology relevant to researchers interested in the subjectivity involved in any situation including the perception of organisational roles, and to the work of Mercer (2006) who used this qualitative approach to gain perceptions on the political, professional and policy drivers leading to the implementation of the Care Standards Act 2000.

Q-methodology is concerned with ‘hearing many voices’ and what makes it unique and important to this study is how those voices are allowed expression (Stainton Rogers 1995). It was central to the study to be able to sample a range of diverse views and opinions. An important consideration in selecting a qualitative approach was that the data collection tool would provide the framework in which participants could tell their story and talk about the ‘realities’ of what was happening allowing for subjective ‘expert opinion’ to be presented in an interesting and non-judgemental way (McKeown and Thomas 1988). It was also considered a more reliable method which would avoid a regurgitation of policy from senior members of staff within the organisation.
Q-sort

The instrumental basis of Q-methodology is the Q-sort technique and conventionally involves rank ordering of a set of statements from agree to disagree.

- Participants are presented with a set of cards on which statements are written (words or pictures could be used).
- Individuals are invited to rank the set of statements along an anchored scale, for example +5 (most agree) through to -5 (least agree with).
- This usually consists of 60-100 cards (the Q-set) and the activity of ranking them is generally known as Q-sorting.
- It is unwise to use fewer than 50 items because it is difficult to achieve stable and reliable results with smaller numbers.
- More than 100 cards, the task may become tedious and difficult.
- Q-methodology allows 'many voices to be heard' through the generation of the statement cards to be used in the sort, the Q-sort and through the discourse generated whilst undertaking the sort.

Modification of the Q-sort technique.

A key decision to make modifications came from the pilot study that identified the Q-sort technique provided a trigger to illuminate the discourse generated around the topic being studied. Conventionally, participants are presented with cards to sort and on completion are asked if they wish to review or re-site any cards or make comments. Modification was made to the more traditional approach as it was noted during the piloting, that whilst sorting participants were freely making comments on the statements and giving justification for where and why they were placed. This was identified as vital data to capture and analyse alongside ranking of the statements. The discourse generated through the Q-sort process was taped
(with consent) and following the pilot, participants were encouraged to unreservedly comment as they sorted and ranked the statements. The term 'discourse' was used throughout the study as it was not a 'conversation' that was held with the participants.

**The Concourse**

In Q-methodology, the communication about a specific topic is referred to as a 'concourse' and it is from this concourse the sample of statements are drawn. A concourse can be sought in a number of ways:

- Naturalistic samples are compiled by obtaining written or oral statements around the topic being explored i.e. focus group.
- Ready-made samples are compiled from other sources i.e. journal articles, literature.

The selection of statements from the concourse for inclusion is of crucial importance. In selecting the sample statements, reference was made to Stainton Rogers et al (1995:249) who reinforce the importance of the final statements selected, as 'people can only tell a story if they have the appropriate statements with which to tell it'. It was important the statements also reflected the perceived chaos and confusion (identified from the audits) surrounding the existing lead professional role for child protection as the concourse is 'the echo of the complexity being studied'.

The decision was made to include items from naturalistic and ready-made statements to form a hybrid Q-sample, so that the participants had a broad
framework in which to illuminate their own perspectives. Statements were drawn together from the literature reviewed for the study (e.g. child protection, primary care, leadership, innovation, and communication), journals articles (Health Service Journal, Children Now), audits (existing perspectives on the role of a lead professional for child protection) and a focus group. This also allowed the voice of practitioners and primary health care team members to be heard and considered by senior members in the organisation in relation to the study topic. 141 statements were generated and a focus group was asked to select the Q-set to be used in the Q-sort.

Selecting the Q-set representative of the range of communicated ideas in the concourse.

Example:

A focus group of existing primary care child protection lead practitioners were asked to look at and prepare the final cards for the Q-sort. The aims were to keep practitioner focused, ensure content validity and reduce researcher bias. They were asked to include widest viewpoints and to generate categories in which the statements could be sorted. Presenting the statements to participants in categories, facilitates the sorting of smaller piles, rather than being faced with one large pile to sort. Four categories were generated: Communication, Roles, Working Together and Responsibilities. The final statements (n=85) were reviewed again to verify the Q-set was representative of the wide range of opinions about the topic in the concourse.

The Sort process

Q-sorting requires the participant to sort the statements along a continuum of 'most agree' to 'most disagree', which is generally undertaken in the presence of the researcher. Consideration was given to whether a 'free-sort' or a 'fixed-sort' would be more appropriate to this study.
- A free-sort where the sorter places the cards wherever they wish.
- A 'forced' where the sorter must balance the sort so that fewer cards are placed on the extremities with the majority of the cards being focused towards the centre of the continuum.

<table>
<thead>
<tr>
<th>Most disagree</th>
<th>No opinion</th>
<th>Most agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>-5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5</td>
<td>1 2 3 4 5 6 5 4 3 2 1</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1: Example of a 'forced' distribution of Q-sort cards (Polit and Hungler 1999:395) showing a hypothetical distribution of 36 cards.

The forced procedure of distributing cards is the subject of some debate. Critics argue this artificial procedure tends to exclude information concerning how people would ordinarily distribute their opinions and that participants' frustration is lowered in a 'free-sort' because they are free to place the Q-sort cards at any place under the relevant distribution markers (Cordingley et al 1997, Denzine 1998, Gaito 1962, Polit & Hungler 1999 and Rohrbaugh 1997). The over-emphasis on fixed sorting is also criticised by Bolland (1985) who points out it may potentially mask important inter-respondent differences and advocates a free-sort as being more reliable as respondents are not required to sort stimuli using what may be an artificially complex system. He also proposes the use of a free-sort potentially increases the content validity of the Q-sort instrument, and since the Q-sort instrument is less complicated than the forced-sort, a response rate may be higher and stimulus statements can be used.

A 'free-sort' was selected as it appeared more compatible with the qualitative and perspective seeking focus of the study and was likely to generate more discourse allowing elaboration on the participant’s beliefs through narratives.
The Sort

A purposive sample of ten was selected to gain a balance of those working at a strategic level in the PCT with those working at a strategic level in child protection within the county. Individuals were written to inviting them to participate, and outlining what a Q-sort would involve. All those contacted, agreed to participate. Q-methodology aims to reveal and explicate viewpoints favoured by a particular group and large numbers are not required. Indeed, Watts and Stenner (2005) warn such an approach could be problematic.

All ‘sorts’ were undertaken at the participants workplace. Written consent was obtained and all participants agreed for the session to be audio-taped. Placing a ‘condition of instruction’ sheet by the respondent during the sort reinforced the verbal instructions given. It was essential to reinforce with participants it is their own particular viewpoint that was required and there was no right or wrong answer to any statements or ‘correct’ way of placing the cards.

<table>
<thead>
<tr>
<th>Most Disagree</th>
<th>-5</th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>1</th>
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<tr>
<td>2</td>
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<td>22</td>
<td>16</td>
<td>1</td>
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<td>5</td>
<td>12</td>
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</tbody>
</table>

Figure 2: An example of how 36 Q-sort cards could be spread using a free-sort condition of instruction.
Q-Sort Conditions of Instruction.

Title: *How should staff be supported in primary care in relation to safeguarding children?*

**There is no right or wrong way to sort the cards.** I am interested in your own personal opinion.

There are four sets of cards. I will give you one set of cards at a time and ask you to sort the cards into 3 separate piles

- The right hand pile for those that you most agree with.
- The left hand pile for those that you least agree with.
- The middle pile for those that you are uncertain about.

In front of you, there is a numbered continuum ranging from -5 (least agree with) to +5 (most agree with). Starting with the ‘right hand, most agree with pile’, please place the cards, in descending lines below the number on the continuum that most reflect your viewpoint.

Once completed, please take a moment to review where you have placed the cards and move any should you so wish. You may find it easier if you review the cards from right to left.

Please feel free to make any comments as you sort the cards or at the end about any of the statements on the cards.

I will record each sort as you move onto the next set of cards. You will be asked to sort another set of cards until all four sets have been sorted.

THANK YOU.

Figure 3: Q-sort conditions of instruction

On completing the sorting of each set of statements, the respondents were prompted to review the siting of the cards and make any changes if they wished.

The aim was to support the reliability of the researcher’s interpretation of the sorting (Stainton Rogers 1991). Despite being recorded, the Q-sort technique appeared to liberate opinion in a ‘politically charged’ area where staff were not used to expressing their personal views.
Preparation of data for analysis

The Ordinal data from each sort was entered onto a record card (reproducing the Q-sort distribution) at the time of each sort and then onto an Excel spreadsheet.

<table>
<thead>
<tr>
<th>Sitting</th>
<th>-5</th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>+4</th>
<th>+5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

Figure 4: The value attributed to each site on the continuum to give an individual sort card score.

Data analysis

In Q-methodology, analysis is designed to identify different sorting patterns and to examine what particular story is being told by each participant (Stainton Rogers et al 1995). In this study, descriptive statistics provided initial data reduction and demonstrated significance in the sorting. Tapes were transcribed by the researcher and individual transcripts were printed on different colour paper and manually coded as described by Burnard (1991). Figure 5 outlines how the data was explored. The factors emerging from the Q-sort data were grouped with the taped discourse to further illuminate the key issues emerging. The data was then explored to see if there were any differences or patterns in the data relating to those working in the PCT being studied with those working in child protection outside the PCT.
1. An overview of the results of all four categories in the sorting process using basic descriptive statistics of highest, lowest and mean score.

2. An overview of results by sort category to include identification of top and bottom sort cards and those most widely distributed.

3. Data was explored in two groups incorporating the respondent’s discourse to see if there were any differences or patterns in the data relating to those who worked in the PCT being studied and those who worked in child protection. (Two respondents worked both in the PCT and child protection).

Figure 5: How the data was explored.

The options for analysis range from the most elementary, descriptive statistical procedures, such as rank ordering, averages and percentages to highly complex procedures such as factor analysis. In the study described, a free-sort was viewed the most appropriate sorting approach and this was incompatible with factor analysis. Watts and Stenner (2005) and Cordingley et al (1997) critique some of the common misunderstandings of the interpretation of using Q-methodology. At the analysis stage of the research process, advice and guidance was sought from prominent researchers through the Q-methodology network (www.Q-method@Listserv.kent.edu) to gain guidance in approach, yet retain a strong emphasis on the discourse and qualitative paradigm.

Figure 6: Influencing literature in the decision-making for data analysis.

Block (1961) maintains the Q-sort method stands alone in its own right as a valuable scaling technique with no necessary relation to factor analysis.

Bolland (1985) argues the correlation model of data analysis is inadequate when a free-sort is used as it continues to mask individual differences in the location and shape of the respondent’s implicit distribution of beliefs.

Brown (1971) proposes most of the statistical information is contained in the item ordering, and that factor types in q-technique studies will be considerably more influenced by ordering preferences than they will be by distribution preferences.
Limitations

A Q-sort requires a relatively small sample of people to get reliable results and therefore minimises costs. Stainton Rogers (1995) identifies that data is highly reliable as it is either drawn from literature or from the perceptions and opinions of 'experts'. Polit & Hungler (1999) describe the technique of Q-sort as being versatile and can be applied to a wide variety of problems. Sorting cards may be a more favourable and less daunting method for participants compared to interviews. This was verified by the respondents who reported enjoying participation in the Q-sort.

Limitations to the Q-sort may be participant’s refusal to sort all the cards as this challenges the reliability of a study. Although Mercer (2006) identified this as a concern, 100% cards were sorted in this study. The method is time consuming, particularly concourse development. However, acknowledging the importance of the final statements selected, the researcher was required to become saturated in the data surrounding the topic reviewed. If she had been presented with statements generated from alternative sources or by other people, this could clearly have affected the validity of the research study. Although the Q-sort can be undertaken via post or e-mail, some researchers have found this problematic (Steelman & Maguire 1996); therefore face-to-face contact with participants involves travel and time, which needed to be built into the time frame for the study. The methodology is relatively unknown and may therefore be unfamiliar to respondents, and it was important to ensure clear instructions were provided. This is viewed as crucial as validity can be affected if participants’ lack of comprehension leads to misrepresentation.
Ethical considerations

Consents and ethical approvals were gained and the pilot was key to addressing any potentially difficult and sensitive issues at the earliest opportunity. Ethical issues were also considered in relation to the role and position of the researcher within the organisation being studied. The researcher is satisfied that the method of data collection selected enabled respondents to present a particular viewpoint on an issue of subjective importance, without being unduly constrained by the viewpoint of the researcher. A method focusing on interviews could have been more likely to produce a regurgitation of policy from the senior staff being asked to participate in the study. Using a Focus Group to reduce and select the final number of statements reduced potential bias. The researcher transcribed and analysed all the data to ensure anonymity of respondents. The sample consisted of ten senior Directors and specialists who could be easily identified; therefore particular care was given to assuring anonymity of the PCT and Locality participating in this study.

Reflection on the methodology

Crucial to Q-methodology is development of the concourse which allows many voices to be heard around the topic being researched. The author argues that because the statements for the Q-sort have been prepared prior to the meeting and contains the 'voice of other people', that the Q-sort is a tool most valuable to researchers studying within the organisation, particularly where participants are senior members within that organisation who may feel their personal views should be reserved, especially when the subject being discussed is sensitive. It would have been of little value to have interviewed the ten participants in the study, who simply recited current policy and not to have been able to express their honest
personal opinions and viewpoints. However, in reality all respondents sorted freely, with 9 of the 10 respondents constantly explaining and justifying why they were placing the cards in their position and the rationale behind their views. The Q-sort process was relaxed and enjoyable for researcher, with several of the participants commenting how stimulating the process had been and it allowed them to freely and comfortably express their views. Several commented the process had been thought provoking and stated it had raised questions for them to take back to their workplace. Although this was not anticipated, similar benefits of the educational benefits of the Q-sort process for the respondents was noted by Mercer (2006).

Example:

| There are some I feel more passionately about than others ... there is one quite interesting one here because ... - R2 |
| I found them interesting for myself ... my value base ... because I thought it important ... that is why I have moved it to +5 (most agree) - R3 |
| I’m going to have to put it there ... yes ... however I’m finding it difficult because ... - R1 |
| I think it has got too great at the moment ... the rate of change ... reform ... reform ... reform is too much I’m afraid - R4 |
| ... a very interesting spread (looks at how cards sorted) ... a very interesting process ... I enjoyed looking at it - R5 |
| The most frustrating thing is communication ... I can’t say enough about communication - R2 |
| I like that (laughs) ... this is an interesting one ... this is true - R8 |

Key issues emerging from the study.

In the study, a number of key issues emerged and recommendations for the organisation were made. Through this methodology, all the research questions were answered. Evidence has been provided that confirms 'child protection is
everyone's responsibility' is firmly embedded across all levels within the organisation. It also acknowledged and confirmed at the highest level within the organisation and other key stakeholders in child protection, that the innovation of lead child protection is needed, valued and supported by the organisation and that communication was still perceived as problematic within GP Practices. Support from the organisation and strong leadership were also rated as important in order to sustain innovation.

Conclusion

The study, set out to gain an organisational perspective to the role and value of the lead professional for child protection within primary health care teams. In conclusion, Q-methodology was viewed as the most appropriate method to uncover different patterns of thought, viewpoints and perceptions from senior members of staff within an organisation on a topic that is emotive and heavily framed in policy and legislation. It allowed the topic to be explored in depth, to 'hear many voices' and to scrutinize areas of friction, consensus and conflict. It also allowed exploration of the confusion, contradiction and complexities surrounding the existing and future child protection lead professional role. Criteria was identified important to a number of senior individuals on the phenomenon being explored and to emerge with recommendations to take forward into practice, supported and owned by the new organisation. The Q-methodology approach has greatly contributed to 'avoiding the politics in child protection research' and to liberating opinion in a politically charged area where senior staff are not used to expressing personal viewpoints and subjective opinion.
References:


Obtained from personal communication with author 5th May 2006


Http://www.nicholas.dyke.edu/people/faculty/maguire/env316/q.5htm


OVERVIEW OF THE INTEGRATION OF KNOWLEDGE, RESEARCH AND PRACTICE
Introduction and context

This paper explores how the taught elements of the Doctorate of Clinical Practice Programme and research study have contributed to the integration of research knowledge into clinical practice. Throughout the four years of study, reference has been made to achieving the Programme Outcomes (Section 1.2) of the Student Handbook 2004.

I came to this programme of study as a specialist practitioner with advanced knowledge and competencies in child protection, aspiring to become a Consultant Nurse. I chose the Doctoral programme as preparation to becoming a future clinical leader, in order to develop advanced research and leadership skills and the ability to apply these to practice.

The Doctoral programme has been undertaken during a period of prolific organisational change and emergent legislation and policy (reference to research study). I acknowledge my own marked professional development during the period from a health visitor with a special interest in child protection to Designated Nurse Safeguarding Children for the County. From this leadership role I am now in a position to lead, influence policy and practice, in order to drive child protection services towards better outcomes for children at clinical and strategic levels. Developing advanced clinical leadership skills facilitated through the programme has been vital in supporting these changing roles with professional and personal development.

The motivation for the direction of the clinical topic selected to study stemmed from a desire to seek out and implement positive change to improve child protection networks and systems to safeguard and promote the welfare of children. Being an effective change agent requires having evidence-based knowledge and the ability to apply this to practice.
The six taught elements of the programme provide the framework in which advanced skills and knowledge have been developed.

1. Introduction to Doctoral Studies

Reflection and vision have been key elements throughout the programme. At the outset it was important to consider the motivation and driving forces of selecting a Doctoral programme. The focus on self awareness allowed review of existing skills and knowledge and self-audit of learning needs and skills needing development, whilst prompting reflection on personal professional visions and goals.

The outline research proposal early in the programme helped to focus ideas and give direction. This allowed establishment of supervisory relationships that provided a strong supportive network from the outset.

An important aspect of the introductory module was building peer relationships, sharing different professional perspectives and providing a ‘safe’ environment to develop advanced skills required i.e. debate in a multi-disciplinary environment.

2. Professional Ethics in a Risk Society

Ethics is a cornerstone to all elements of practice and academic study. The advanced knowledge and skills developed has been a central theme incorporating all work undertaken in the programme and most valuable to my developing role, in particular the in-depth exploration and debating around accountability. Key to ethical considerations is the principle of ‘no harm’. Working at a senior clinical and strategic level in child protection, faced daily with ethical dilemmas, risk assessments, supervising and advising colleagues in a multi-agency environment is challenging. This requires high level skills to make appropriate assessments and justify the decision-making process with confidence. The ethical decisions made in practice often require fine balance
between intervening to protect the child with protecting the child and family from unwarranted intervention. Working in a constantly changing policy environment, requires the need to interpret, implement and make decisions that implicitly or explicitly reflect a particular set of values and beliefs. The module provided further insight into my own unique set of values and beliefs whilst trying to reconcile the macro and micro politics and policies which frame the inter-agency environment.

3. Advanced Research Methods for the Reflective Practitioner

This module provided a solid foundation for development of research knowledge, to explore and analyse a broad range of methodologies and approaches to advanced studies. Development of advanced knowledge allowed selection of the most appropriate methodology to undertake an in-depth study into the value of the Prime worker innovation. Most valuable was the 'hands on' exploration of Q-sort and Q-methodology. Q-methodology was previously unknown to me but the session provided stimulus for further exploration of suitability to my own research project, including the most appropriate framework to incorporate the theoretical perspectives and contribute to the originality of the study. The methodology selected was challenging to a researcher used to a more straightforward qualitative approach. However, the level of supervision provided through the programme allowed me to gain confidence in using this methodology, but it was a steep and intensive learning curve. Selection for the focus of the paper for publication supports this development and reiterates its value for studies undertaken within an organisation. Consideration will be given to using Q-methodology in practice for future clinical research and also utilising the knowledge and skills gained from the module programme (including the use of a variety of data analysis tools). Development of advanced research skills is outlined in the Research Log.

The module developed the ability to critically evaluate, integrate research literature and to apply this to my own area of advanced practice. This is
demonstrated through the work assignments and research provided within this portfolio. A key element of the role of Nurse Consultant is to undertake audit and research. The skills acquired during the four year programme have contributed significantly in building confidence and competence to undertake audits and small research projects in practice within my own agency and wider multi-disciplinary environment working as a member of the Local Safeguarding Children Board Audit Group.

Additionally confidence has developed in the ability to analyse and interpret literature and research, allowing dissemination through summary papers, seminars and presentations. This includes presentations of the Service Development Project and Research study findings. Throughout the period, opportunities arose to discuss the innovation of the Prime worker for child protection at numerous formal and informal forums. The research study brings together all work undertaken whilst on the programme and outlines how the findings of the study will be disseminated. The research study findings provide evidence to sustain and strengthen the role of Prime worker and to provide direction to the nPCT.

4. Policy, Politics and Power

This stimulating module was thought provoking and influential in providing a significant foundation for personal and professional development. It reinforced previous learning and experience allowing further refinement of analytical skills and provided a lever to gain insight into policy analysis. Working in a senior leadership role in a climate of constant organisational, policy and legislative change, it is vital to develop insight into how the political agenda and policy drivers influence decision-making processes. It has been important to develop skills that reflect and understand these drivers of policy and change, enabling challenge and championing of the decision making processes where appropriate within specialist practice (within my own agency and in a multi-disciplinary context).
On reflection, I came to this programme of study politically naïve and initially felt de-skilled; however the enthusiasm of the module team was empowering and conducive to learning and development. Noticeable to personal development and application to practice was the ability to constructively challenge and debate from an evidence-based standing. I have developed the discipline to take on a wider view on material presented, to critically analyse the drivers and the likely impact of policies and politics. These are vital skills required to support the development of enhanced clinical leadership. The debate was extremely significant in developing these skills (see reflection in appendix) and one of the most memorable and 'powerful' events of the programme.

As the programme developed I became a more politically astute health professional gaining confidence and competence allowing me to assert my position at senior executive forum. I acknowledge this area needs further development but believe this will come with increased experience.

‘Learning whilst doing’ allowed reflection in action and questioning of present practice and policy, and development of proficiency in shaping future practice. The module helped understand that working in a highly politicised environment creates emotional tension, which has been an important consideration through the research study.

5. Communities of Practice

This module was significant in understanding where knowledge comes from, exploring how professional knowledge and expertise can be developed into practice and how new knowledge is created in communities of practice. As lead nurse for safeguarding children within the county, this involves building strong relationships in a multi-disciplinary team working with common goals and procedures to achieving safer and better outcomes for children. The theory explored was illuminating allowing reflection on my professional identity and competencies working in a multi-disciplinary environment, considering the
challenges and benefits of communities of practice, developing new forms of knowledge, ways of working and current complexities of developing more integrated working. This was explored through the Policy Analysis assignment and carried forward through the research study as drivers for change also providing challenges to existing communities of practice. The chaos theoretical perspective highlighted such complexities of change as well as the risk that as agencies become more integrated, professional knowledge and boundaries can become blurred and professional identity can be challenged as roles and responsibilities change.

The philosophy within the module was challenging and generated a steep learning curve as a new area previously un-studied. However as a trained teacher, the philosophical stance within the module developed different perspectives to looking at how knowledge is gained and understood.

6. Emotions, Leadership and Innovations in Organisations

During the period under study, there has been prolific organisational and policy change. It was important to explore and develop different leadership and change management skills that can be applied to practice. This was timely to progression of my own professional development. Different theories and literature explored and debated on the module provided a solid foundation and were further examined in the research study. It is acknowledged in the research study that from a leadership role, striving to provide evidence to sustain innovation in order to safeguard and promote the welfare of children, it is important to embrace rather oppose change, and learn how to manage it. The module examined different aspects of innovation and leadership providing advanced awareness, which has migrated to practice, particularly in the Service Development project and research study emphasising new direction for the innovation explored.
The development of analytical skills to solve complex problems has allowed me to develop into an empowered practitioner, bringing new practices forward from a position of competence which has been acknowledged through marked career progression and recognised by health professionals and multi-disciplinary colleagues who allow me to influence their thinking and practice. Key to the Consultant Nurse role is developing the ability to switch between practice and policy.

I have learnt the importance of delegation and the development of leadership skills in others as my role has developed. It is important that individuals within the organisation are invested in to ensure long term sustainability. It has been important to reflect on leadership styles and to explore and develop what contributes to effective leadership. Developing transformational leadership skills is viewed as central to the Consultant Nurse role. Personal and organisational emotional intelligence is a prominent feature throughout the research study and an area of personal interest to be explored in the future. Additionally, consideration is being given to developing further skills through the NHS Leadership Programme.

Exploration of chaos theory was influential in the theoretical direction for my own work, and has been usefully applied in the research study acknowledging that effective leaders learn to tolerate a certain level of chaos, uncertainty and lack of structure. This theoretical stance allowed the perceived chaos of the Prime worker role to be explored in-depth and to emerge with direction for new order.

Conclusion

The Doctoral programme was developed to support clinicians in undertaking a higher level of research and contribute to counteracting any theory-practice gap. The knowledge and skills developed on this programme has facilitated marked professional and personal development. From a leadership role, I am now in a
position to lead, influence policy and practice and drive child protection services towards better outcomes for children – ‘to make a difference’.

The programme allowed me to step back and reflect on practice. It has been difficult to analyse the changes occurring and future direction required when one is right in the middle of the change process itself. The varied programme design has helped me develop wider perspectives on my specialist area of working and understand where and how things fit together (or not); the importance of working in multi-disciplinary environment has been constantly reinforced and strengthened.

I come to the end of the four year programme with a clearer vision of ‘where I am, what needs to be achieved and the limitations’. I have developed advanced skills in order to work more efficiently, effectively and have gained confidence in my ability as a clinical leader to drive forward the safeguarding children agenda. The practice-based programme allows a clearer transference of lifelong learning into the clinical environment. I have developed the ability to receive information (in various forms), to assimilate it and make my own meaning. There is still more to learn but the Doctoral programme has provided a firm foundation from which to move forward.
Appendix 1

'This house believes that government policy of increasing lay involvement in health and social care erodes professional power'.

Specific Doctoral programme learning outcomes contributed to through process of preparing and participating in the debate:

- Be a politically astute health and social care professional.
- Have the ability to lobby and politically argue from an evidence base.
- Demonstrate excellence in communication skills.
- Critical understanding of how policy is driven, conceived and developed.
- Increase political awareness and understanding of how to influence the development and delivery of health and social care policy.
- Critically argue the advantages and disadvantages of the use of evidence-based practice in the development of health and social care policy.
- Critically analyse the use of evidence-based practice in care settings.

As part of the module 'Politics, Power and Policy', the first year students on the Doctorate of Clinical Practice programme were invited to participate in a debate. A poster was put up and staff and other students from the University were invited to attend.

Six students were split into two teams, one proposing and the other opposing the motion. Information was sought about the process of a debate, the skills that would be required and those needing to be developed prior to the debate. Policies and literature was widely explored around the topic. As an opposer to the motion, our goal was to prepare and plan strategies to attack the proposing team and to eliminate their 'impact scenarios'. Working together as a team, literature, tactics and ideas were shared, many of the ideas stemming from experiences in practice and work undertaken for the policy analysis assignment.

It was important to consider the stance that the proposers may take and to try and plan strategies to counter attack. As a team, we explored the Key policy drivers for Patient and Public Involvement (PPI), including the NHS Plan (DH
2000), The Bristol Royal Infirmary Inquiry and Health & Social Care Act 2001. We questioned the meaning of the words ‘what is professional’, ‘involvement’ and ‘power’ – power to do what? - Power was not one way. Does the erosion of power spread to other professionals outside the health system, or within the health system but outside the NHS? The historical perspective of PPI gave strength to the argument as examples were given that involving patients and the public was nothing new – just being reworded and re-launched. The benefits and results of PPI were explored and lay and professional perspectives and robust examples given both nationally and locally to clearly demonstrate that PPI far from eroding professional power, actually gives it strength. These examples were used to demonstrate how these policies empower professionals to do more for their patients. Sure Start, being a successful example of involving people – empowering people – giving people skills, and it is this that empowers professionals and strengthens their power to ‘do good – the greater good for the greatest number’. In the aftermath of the Inquiry into heart surgery at Bristol Infirmary, promises were made about how the needless deaths of children would be prevented from ever happening again. PPI has been a key issue and strong driver of policy and must be seen in the context of our determination as health professionals to be more open and responsive and to make a safe health and social care service. As opposers to the motion, our team argued and provided evidence to the house that PPI increases power and trust in professionals and therefore we believe that the government policy of involving lay people in health and social care strengthens rather than erodes professional power.

My initial reactions to being asked to participate in a debate were mixed. The enthusiasm of the staff that prepared and guided us made it seem exciting and fun. However, never having participated or even observed a formal debate made it also feel daunting. Luckily, one member of the team was experienced in debating and began to build our confidence and ability to achieve this task. Throughout the preparation for the debate, it was crucial to work as a team to share ideas, possible tactics and examples that may be used to challenge the proposing team. It was also important to share and explore the policies and
literature as a team in order to centralise our team's argument. I believe that I was probably the least confident member of the team, having identified a personal weakness of not being confident at 'talking on my feet'. I have been a qualified teacher for four years, however, this was not a subject I felt I could talk and argue freely about. Teaching sessions are thoroughly prepared and planned and mostly around my specialist professional expertise and the thought of having to stand up and counter-argue 'on my feet' in front of my colleagues and students (as I am also a member of staff) and possibly make a fool of myself was unnerving. I was assigned the task of summarising. On the day, the debate went well and I certainly enjoyed the experience. With guidance and support I had prepared my response to a certain degree in order to re-affirm our team's argument and to stress the key points that we believed proved our case. I had also developed skills that were used on the day to refute and try to discredit the proposer's argument.

The positive outcomes of this exercise were the team building and working together that went on in preparation for, and on the day of the debate. Working with health professionals from different disciplines and one from outside the NHS was so valuable in seeing different perspectives. This exercise also built on the knowledge and skills gained through undertaking a policy analysis assignment and consolidated the module 'Policy, Power and Politics'. This module has been very powerful in bringing about personal and professional development, in particular in being more questioning and politically aware. On reflection, it would have been very useful to have a practice debate prior to the 'big event' where skills could be developed and practiced in a safer environment. As a student group, a request was made that only students would attend the debate. However, no students attended as being 'Practice Development week' for staff, there were no students around. We do feel that the staff facilitating the debate could have been more honest with us, I certainly felt uneasy about participating in a debate for the first time with many of my work colleagues in the audience.
Linking this experience to my own practice, it has been a steep learning curve that has provided the springboard for personal and professional development. As a specialist practitioner and clinical leader, effective oral communication skills are vital. Presentation and debating skills are continuously used at Board meetings, multi-disciplinary, staff, multi-agency meetings etc to justify an initiative, argue a cause or to try and bring about change. The opportunity to develop my skills further has been invaluable.

This experience has empowered me to want to participate in a debate again. Although, I still do not feel confident, the skills developed from participating in formal debate far out weighs the anxiety of participating. With more practice, confidence and competence should develop. Next time, I would like to be a first proposers or opposer. Debate should become a more regular part of the Doctorate programme.

The model of reflection used in this work was Gibbs (1988).

References


Safeguarding Children in Primary Care: A Critical Review of the role of the Prime Worker – Necessity or Luxury?

by

Lorraine Mary Smith

THESIS
Submitted for the degree of Doctor of Clinical Practice

PART TWO
Policy Review
Service Development Project

Faculty of Health and Medical Sciences
Division of Health and Social Care

University of Surrey

February 2008
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Statement of Originality

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification.
POLICY REVIEW IN SPECIALIST FIELD
1. Introduction

This assignment reviews the current Child Protection Operational Policy for the Primary Care Trust (PCT) where the author is based. Policy within child protection is underpinned by legislation. It will be explored in relation to past and current policy, as the two cannot be clearly separated, as there are strong historical influences on current policy. This review provides the policy context for a research project that will focus on child protection in primary care, particularly the role of the Prime worker. The Operational Policy will be evaluated and influencing drivers to this policy will be identified and critically evaluated in the context of the impact on practice and service delivery. The political, global and strategic influences impacting on policy-making processes will also be explored and debated. It is within a climate of constant change within Health and Social Care that provides the milieu for this study and within an ethos that change should always be used as a means of bringing about better outcomes for children (DH 1999).

For policy (like child protection) driven by Government, Harrison (2001:90) highlights 'what governments do, and why they do it, and what difference it makes' as a useful definition on which to focus analysis. This is the framework used within this assignment that will also draw on the work of Gunn (1978 see appendix ii) adapted by Harrison (2001:97). Benson's (1983) model of policy analysis also provides a helpful framework for the analysis of the internal dynamics of multi-agency networks operating within child protection. This model is based on equilibrium across four key dimensions (appendix iii).

In Western Society, a young person becomes an adult upon reaching the age of eighteen. Prior to this they are seen as vulnerable and in need of protection. Their rights are recognised, yet are also highly circumscribed by legislation, policy and procedures. Childhood's special status is reflected in the laws and policies that have formulated over time and research abounds analysing conflicts and debates that have been worked through to an overall consensus about the importance of safeguarding the welfare of children and family unit. This concordance has developed and been applied irrespective of the political party that has been in Government over the last hundred years, although the focus of different political parties may differ (Lupton et al 2001).
Safeguard Children’ (DH 1999) is the current policy document that provides a national framework for how all agencies should work together locally to promote children’s welfare and protect them from abuse and neglect. It reflects ideology and the global principles of the 1989 United Nations Convention on The Rights of a Child.

2. Historical context
2.1 Prior to 1995

Current policy on child protection does not represent a new beginning; it has been fundamentally influenced by what has gone before. Therefore, historical context is important in that protection of children has required a national policy response that is interpreted and applied at a local level. Fox Harding (1991) summarises the historical drivers of child care policy in that factors influencing law, policy and practice can be divided into four broad areas: scandals, inquiries and the response, interest groups and their thinking, reviews of legislation and policy and wider policies and changes. In today’s society, what must also be added to that is the impact of changing families and what is now seen as ‘the family unit’.

Child protection policy originates back to the pre-modern 1600’s (Tindall and Alaszewski 1998). Although the NSPCC was formed in the late 1890’s, there was reluctance to intervene in family life as children were viewed as being ‘owned’ by their parents. For the purpose and length of this study, prior to the 1960’s although fascinating reading will not be explored here.

In the 1960’s, emotive terms such as ‘battered baby’ were used. This focused heavily on physical signs of abuse and historically highlighted society’s growing sensitivity to the occurrence of child cruelty. The 1974 Report into the death of Maria Colwell was crucial in determining the pivotal role of the interagency system (DHSS 1982). Maria’s death caused a public and media outcry that led to significant development in child protection policy and practice. Maria’s inquiry was followed in the 1980’s by other high profile child death Inquiries that severely criticised roles and responsibilities of professionals involved with the children and their families. One response from emerging inquiries was the formation of Area Review Committees whose role was to ensure local agencies involved in child
protection work together effectively (London Borough of Brent 1985). This decade is an important milestone forming the foundation for multi-disciplinary collaboration of policy today, although the legislative ‘duty to cooperate’ did not come until the 1989 Children Act.

Hallett and Stevenson (1980), Parton (1985), Watton (1993) and reinforced by Parton (2004) argue that historically repeated child protection failures had resulted from poor collaboration. Yet despite over thirty years of policy development, it is still top of inquiry report recommendations (Laming 2003). Repeated failures are compounded by the fact that it takes time for policy to be implemented and changes to occur. Governments responded swiftly with new policies to recommendations from Inquiries- ‘seen to be doing something’ yet the implementation and resourcing of these changes takes time and unfortunately further policy changes are waiting to be implemented before the impact of the last change has often been recognised. Exploring underneath the similarities over thirty years, there is recognition that there are now emerging differences in Inquiries over time. Parton (2004:82) explores and compares Colwell in 1974 and Climbie in 2003 and argues that:

By implication, it is the child protection systems introduced in the light of the various child abuse Inquiries over the last thirty years which are seen as much a part of the problem (today) as the solution.

He argues development of the systems to protect Maria was a contributory element of the failure to protect Victoria. This perspective will certainly need to be given thought by those involved in future collaboration.

In the 1980’s, research was published around identifying characteristics and risk factors for abuse, particularly the work of Browne and Saqi (1988). The significance of this for policy makers in the late 1980’s were several other high profile inquiries i.e. Cleveland (1988) that began to question professional knowledge and procedures amongst professionals as well as in the media. Professionals were faced with trying to manage the fine balance of intervening to protect the child with protecting the child and family from (unwarranted) interventions. The impact on policy was a shift to assessment and
management of risk becoming central within child protection. At the same time, the concept of the family became less rigid and this has ultimately impacted on policy. Inquiries over the last thirty years reflect significant societal and cultural changes that have become evident in this country. There is considerable variation and complexity in household and family structures and relationships, such that the model of the traditional nuclear family no longer seems to resemble the majority of the population. In this aspect the term ‘family’ rather than the family is now used. Featherstone (2004) explores the major challenges this poses to professionals and agencies working in the context of such variations. Changing society has also led to ‘loss of the extended family’ where families do not have the traditional family support networks that may have acted as a ‘buffer’ to a child in a family under stress. The other major area of social change concerns globalisation and global mobility. Parton (2004) argues that with Maria Colwell, it was the cultural differences in relation to social class and gender that were significant, but the shift to issues of ethnicity and race with Victoria Climbie was more evident as well as the ‘loss’ of stability and cohesion of local communities that has changed.

2.2 Messages from Research (DH 1995)

The current legislative framework for child protection in England is the Children Act 1989, based on the principles of the 1989 United Nations Convention on the Rights of a Child. Messages from Research (DH 1995) was funded by The Department of Health following the high profile Inquiries in the 1980’s. It summarises and disseminates the results of twenty childcare research projects commissioned following identification of a gap in knowledge, and to the responses made following identification of child protection concerns. It was these studies that have provided major insights into the operation, decision-making and outcomes of child protection systems and processes and posed many questions in the late 1990’s for policy makers and practitioners leading to debates about the future direction of child protection.

Parton et al (1997) explore further some of this research, particularly how children and families were filtered through the child protection process and describe studies nationally and internationally that highlight the significance of this to the late 1990’s re-think and re-
evaluation of the child protection policy and practice within the UK. The Conservative
Minister for Health (DH 1995) urged practitioners to become evidence-based practitioners,
launched 'Messages from Research' with a high political profile. Parton et al (1997)
reinforce the developing ideals that future policy and practice in the 21st century would be
informed by detailed empirical research with a shift to looking at children in context of
what is happening, rather than focussing on isolated incidents. Also, that too many cases
were being dealt with under child protection procedures and these should be dealt with
under family support provisions. This debate is supported in the 1994 Audit Commissions
Report recommending that joint service plans become mandatory to reflect joint
operational intentions. These were subsequently implemented in 1996.
This initiative supports Benson's (1983) model of working towards 'equilibrium of the four
dimensions' — Domain consensus, Ideological consensus, positive evaluation and work
coordination (appendix iii).

Tensions and frustrations arose between health and social services agencies as to
provision and support for early intervention for children and families (a desire to protect
the vulnerable and the reluctance to commit sufficient societal resources via the state).
Resource implications and priorities led by late 1990's to a referral criteria and threshold
and to a shift to 'Children in Need' and this began developing the formative ideas of a
holistic ecological approach to the care of children. This ideological dissonance between
agencies led to a re-balance of child protection work with greater emphasis placed
towards 'children in need' of support than focusing heavily on 'children at risk'. The
current Working Together to Safeguard Children policy framework (DH 1999) and
Assessment Framework (DH 2000a) were compiled as a response to the recognised
deficiencies in the system and incorporated the research findings into a multi-agency
guidance and best practice - ideology. These documents provide strategic guidance from
which operational instructions and policy at a local level are formulated, as well as
guidance as to how agencies should work together. They also strengthened the shifting
focus from 'improving communication' to 'working together'.

In reality, it has not been easy to implement. Preventative resources for children 'in need'
have often not been available until a child became 'at risk'. Social services needed to
establish criteria in order to manage the volume of referrals and this most often excluded the children identified as 'in need', the reality of alternative resources 'out there' often not found to replace previous provision. Haringey Children's services in the aftermath of the death of Victoria Climbie swiftly reassessed referral criteria stating: "We realised our definitions of need were too high and it had led to a vicious cycle – not enough preventative work" (Cook 2004:18). The Governments changing policies on nursery provision led to social services not being able to offer financial support for placements to vulnerable children, as the policy on 'free' places for all children had not been implemented. There is and has been conflict here with Gunn's (1978) conditions for effective policy implementation – specifically conditions 1-5 (appendix ii).

2.3 Child protection policy in the 21st Century

In response to The Laming Report (2003), The Government published in 2003 a Green Paper 'Every Child Matters' which proposed further changes in policy and legislation focusing local services more effectively around needs of children and families. The Children Bill was introduced into the House of Lords in March 2004 and gives effect to legislative proposals set out in the Green Paper. This legislation will undoubtedly bring about major policy changes that will impact on and juxtapose existing child protection policy and procedures. The vision set out in the Green Paper is the present Labour Governments long-term vision to integrate key services for children within a single local organisational focus. The development of Children's Trusts by 2006 will bring together and integrate front line service provision of services to children, young people and their families – '...a range of measures to reform and improve children's care... bring together under one place under one person services for children' (Tony Blair 2003, Foreword in Every child Matters). This will be facilitated by Trusts being able to commission services to achieve local integration, with the aim of strengthening and formalising Working Together and local Partnership arrangements. Evidence emerging from The Laming Report (2003) confirmed many of the messages from previous Inquiries into child protection failings (DH 1995). The Bill cements the present Governments commitment to ALL children, particularly to those in need of support to try and prevent them becoming children in need of protection. The Labour Government further cemented this commitment by appointing
Margaret Hodge as the first Minister for Children. The Department for Education & Skills through central Children’s Trust Teams will develop national policy and necessary legislation to help enable this process. The National Service Framework for Children (NSF) will be a key element in setting the standards for services to help achieve these outcomes. Underneath this ideology, the researcher remains sceptical. Concerns are emerging about the Children Bill, particularly the long term funding and roll out of existing projects like ‘Sure Start’ (Taylor 2004). With change must come finance and with policy must come the means to fully implement the initiatives, not just the pilot sites! – Gunn’s (1978) condition 1 & 2 (appendix ii). These imperatives relate centrally to the need to ensuring a secure supply of resources. Gribsby (2004:16) argues that although multi-agency collaboration is fuelling the logical next step in the development of information technology, "often it is not the technology that is the problem but the political will to fund it and engage in the necessary process and cultural shift". A significant feature of the role of Commissioner receiving global international significance and debate is the Commissioner for England could lack the independence and powers of investigation that many practitioners believe crucial for a children’s advocate and champion (Martin 2004a, Marshall 2004, NSPCC 2004). These concerns are reinforced and strengthened by the European Network of Ombudspersons for Children writing to the House of Commons joint committee on Human Rights:

...and unless there is much greater measure of independence from government, it seems the new commissioner may end up an outcast from the wider community of children’s champions across Europe (Dobson 2004:18-19).

This signifies the Commissioner has been tied to governments set outcome goals, not understanding that to be effective, the post must be completely independent of government. Area Child Protection Committees, the forum for most local policy is to become a ‘Safeguarding Board’ (DfES/DH 2004a). There are concerns how this will function, the level of accountability and who will sit on these forums – managers with budgets or skilled practitioners with knowledge? (Gunn 1978 condition 6 – see appendix). Change is happening so fast within the NHS there is little time to implement, reflect and assess any benefits. Whilst this focus on integrating health and social care services to children is welcomed by those working with children, it has raised issues about inequalities
for adult health and social services (Glasby 2004). This has been explored further later in this assignment.

3. Analysis of current policy.

3.1 The PCT Operational Policy.

The PCT Operational Policy (appendix i) was re-written in early 2004 as the existing policy did not clearly address the national policy guidance as laid down by the Department of Health (1999), the local procedures as laid down by the xx Area Child Protection Committee (2000) or reflect the recommendations made in The Laming Report (2003). The policy states the underpinning philosophy and commitment of the PCT in respect to the protection of children, and states that its purpose is to provide a framework that describes the systems in place that guide all those working within the PCT. The operational policy has influence on other policies; mainly the training and supervision policy within the PCT. Policy within child protection at a macro and micro level are constantly changing but is driven by a political and societal altruistic desire to improve the welfare of children. At a macro level, policy is driven by legislation and by government initiatives including the work of the Audit Commission. The driver of the Governments decision-making is often a response to a high profile child death inquiry. Back in the 1970’s this was Jasmine Beckford to Victoria Climbie in 2003. Although policy has been developed over this period of time and positive changes made, other aspects have not. Repeatedly highlighted as a major contributory factor in the majority of child death Inquiries, poor communication and training have been identified (Bichard 2004, DHSS 1982, Laming 2003).

It is the scope of the operational policy that has shifted since the introduction of the ‘Working Together to Safeguard Children’ policy document was implemented in 1999 and Laming (2003:43) reinforced this. Previously, child protection within ‘Health’ was deemed the responsibility of those whose work brought them into direct contact with children and their families. This shift has broadened to include all staff, widening responsibility and has significantly impacted on the service from the researcher’s perspective both strategically and at the delivery level. The implications and requirements of this on the provision of
training and supervision support for all staff, rather than just those who work directly with children and families are not to be underestimated. It is likely that this level of training will also be a requirement within the National Service Framework for Children (DH 2004c) as the contents of the document are recognised.

Jacqui Smith MP clearly defined the child protection responsibilities in her paper to PCT’s dated 28th January 2002. This was a response to *Shifting the Balance of Power within the NHS: Securing Delivery* (DH 2001), part of the Government’s 10 year Modernisation Plan which stems from the NHS Plan (DH 2000b). It enumerates that as power is being shifted ‘down the line, it is essential that a proper focus on child protection is maintained’. Lupton *et al* (2001) explore how PCT’s can achieve this through the role of Designated and Named health professionals.

Changing political, economic and social climates, demographic and contemporary technological developments, influence policy changes at the macro level. Over the years, particularly since the present Labour government introduced ‘The Third Way’, the political emphasis has greatly shifted to ‘joined-up thinking’ and multi-agency working as a means of addressing complex health and social problems and this has strengthened existing policies. At a micro level, factors such as multi-organisational and professional cultures, organisational resources and competing policy agendas are relevant. Lessons learnt have cemented the developing theory that individuals cannot and should not work alone in the protection of children and that ‘Working Together’ can and should be the only way forward. Legislation has enforced this as The Children Act 1989 places two specific duties on agencies to co-operate in the interests of vulnerable children (Section 27 and Section 47). At a micro level this has been implemented through the multi-disciplinary approach to the implementation of policy through The Area Child Protection Committee (ACPC) procedures and individual agency policies and procedures that supplement this. However, the weakness here has been judged time after time to be able to effectively apply this. Why? Policies should not only be politically acceptable but also technically effective (Benson 1983, Harrison 2001). An example that demonstrates this is that 90% of patients get an appointment with a GP within 24 hours, focusing on meeting government targets.
The impact of the patient experience is not given consideration i.e. continuity of care with a specific GP or choice to book in advance (Audit Commission 2004).

3.2 Political influences on policy

Legislation underpins and guides child welfare policy irrespective of the political party in power. So what role does the government have? As long as Government is committed to the NHS being free at the point of delivery, they will always have strong influences, power and control over policy decisions and implementation. Yet it is also realistic to acknowledge that whilst the needs of children should be top of the political agenda, Harker (2004) and Kings Fund (2004) argue they could also be easily lost in the allocation and demand of public spending and competing policies.

The budget in March 2004 indicated the political importance of children to New Labour and the likely role that children’s policy will play in the election manifesto. For Labour, a number of factors influence their policymaking; most significantly, the election commitments of 1997 and 2001. Tony Blair stated credibility on overseeing the major changes in the NHS. Whilst this could be seen as favourable for the moment, there remain serious concerns for the government to address, particularly relating to long-term funding, expansion and sustainability of many of the recent government initiatives. The gap between national policies and their implementation at a local level is becoming more evident (Harker 2004, Smith 2004). The ideology of these initiatives can be seen to be working well in pilot sites, but there is a developing criticism that the feasibility of rolling these services and projects out across the country will lead to inequality and a ‘watered down service’ – the language in powerful statements of initial policy directives ‘will have’ may become ‘may have’ and this loses power and strength as the policy is disseminated.

These concerns have been argued and debated particularly in relation to Sure Start projects and Children’s Centres (NSPCC 2004, Taylor 2004). Although the present Labour Government give assurances this should not happen, pressure groups and interested parties are not convinced and are questioning the governments commitment to preventative work which impacts on the health and welfare of children (Harker 2004).
On the one hand the government says prevention services at a local level are vital but on the other, it is not helping to achieve this (Smith 2004:12).

In this same article Pugh is quoted questioning 'where does prevention fit in the governments forward strategy?' Five years on from the Prime Ministers historic pledge to end child poverty within a generation, the question remains as to how the government plan to achieve this. Albeit, Chancellor Gordon Brown in July 2004 unveiled an ambitious new target to halve the number of children in material deprivation by 2010 and to extend Children's Centres from 1,700 to 2,500 by 2008 (Martin 2004b). The NHS Improvement Plan (DH 2004b) sets out the priorities for the NHS between June 2004 and 2008 yet children or links to any other key government initiatives for children were not mentioned. There is conflict here with Gunn's (1978) theoretical model of conditions for effective policy implementation (condition 1, 2). Within childcare policy, there has been a shift to prevention and towards children in need, rather to a focus on those 'at risk'. Therefore the government must be seen to provide the foundations to support this focus on prevention for future policy to be effective.

With a general election due possibly next year, will there be consensus or conflict about children in the election manifestos of the various political parties? There is no sign so far that children's services will be a battleground for the next election. There may be differences between parties on the level of resources that services might expect to receive, but there is unlikely to be little dissent on the overall approach as it is underpinned by legislation. All parties agree on the need for more joined-up services and a focus on prevention as well as protection. Different governments may interpret differently but the foundations of policy issues remain the same as all ultimately want the same outcomes for children. Harker (2004:15) reinforces this further:

_Campaigners have grounds to celebrate - none of the main political parties are contesting the need for greater investment, or the need for action on child poverty child care and child protection... Continuity is likely whichever Party wins._

A term used within child protection is 'in whose best interests?' This is a useful question to ask when reflecting on political decisions and initiatives and not always to accept them at
face value. Hopefully the answer would be ‘the children in our society’, but it is also important to consider other elements like whether the timing of certain reports and initiatives were crucial and why? To consider ‘what is in it for them’ (the government) i.e. votes, being seen to be ‘doing something’ about a high profile issue (Hayter 2004). Harker (2004) also proposes caution, that there is a degree of danger in any political consensus that could give way to silence, whereas what is needed to make progress on children’s policy is ‘momentum and debate’. This is a key point within a political arena of constant change, new initiatives, limited funding and resources to be bid for.

It cannot be assumed there will always be an NHS as we know it at present. Therefore, the child protection systems being developed now must be robust and freestanding to withstand any significant distancing from the present situation. The formation of multi-agency Children’s Trusts is a step in that direction. Dewar (2003) in a study undertaken through the Kings Fund takes this further, questioning and debating whether in modernising the NHS it is now time to consider the NHS to be funded, delivered or regulated through agencies working ‘at arms length’ from the government. Establishment of an NHS Agency, accountable to Parliament is debated and questions whether the NHS needs to be freed from political interferences and allowed to get on with the job of delivering care within a broad, agreed policy framework (Kings Fund 2004). This document probes the conceptual and practical challenges – as well as potential benefits of ‘arms length government’ for the NHS. Conclusions are drawn that this new relationship could make the:

*NHS more accountable, encourage a more transparent and inclusive approach to setting national health policy and create greater ownership of targets by NHS staff” (Dewar 2004:1).*

If this is to be the way forward then consideration to the theory underpinning effective policy change and implementation like those analysed by Gunn (1978) or Benson (1983) must be given serious consideration.

Within the arena of protection of the ‘vulnerable’ in society, children have a high profile. With changing demographics, there is a growing imbalance towards higher numbers of older people than children and conflicts may arise for funding and resources to implement
different policies particularly the management of chronic illness which "impose a huge burden of ill health in the UK" (Lewis et al 2003:10). The elderly and children, particularly under five year olds are placing an increasing demand on resources. With less children being born, this will have an economical impact on the future workforce (Audit Commission 2004). As with any national initiative, services and resources are often targeted to those identified as most in need. The producer/dependency ratio is changing, yet the protection of vulnerable adults does not receive the political attention and resources that are directed to children. Health Minister Stephen Ladyman in August 2004 called for a 'radical think' (Glasby 2004:17). Prichard (2001) identifies this tension and reflects on 'who has heard of Mrs. Lily Lilley?' – Yet a child murdered her, put her in a 'wheelie bin' and pushed her into a canal. Victoria Climbie's story hit the media headline for two years. Mrs. Lily Lilley's story was a small insert in a Sunday newspaper. Whereas the Children Act 1989 provides the foundation for children; there is as yet no similar legislation with such strength for vulnerable adults. There is some legislation through The Care Standards Act 2000, national and local policy and procedures, and a growing awareness but there needs to be a more proactive, political engagement to vulnerable adults.

The Conservative Government under Mrs. Thatcher really began to focus on developing Primary Care. The New NHS Modern Dependable (DH 1997) put forward a new way of running the NHS based on partnership, driven by performance. Since 1997 when Labour came into power, the concept of working together and collaboration within Primary Health and Primary Care Teams has been markedly developed (DH 1998, NHSE 1999). The NHS Plan (DH 2000b) provides the framework for the 10 year Modernisation of the Health Service. Implementation of National Policy documents 'Shifting the Balance of Power' (DH 2001) and 'Shifting the Balance of Power: The Next steps' (DH 2002a) provide examples of how change reforming the way the NHS works, its main feature has been to give locally based PCT’s the role of running the NHS and improving health needs locally. At a local level, policies have been implemented involving clinicians across all disciplines in the decision-making process of the changes brought about within primary care. The aim is to improve services by giving those who deliver healthcare a greater say in how the service is run and delivered. This involvement of clinicians and devolution of power has been
positive locally. There has been more engagement and 'ownership' which has been a strong driver to the development of local policy and implementation of national policy from front-line staff. However, Dickson (2004:iii), Chief Executive of The Kings Fund, argues that the degree of involvement of clinical staff in the working of PCT's has been disappointing and the expectations that they would be in the driving seat has not been realised. Beavers (2004:4) reiterates this to PCT clinical staff who:

...must now seize the day... and exercise their latent entrepreneurial flair and exercise the influence that is legitimately theirs... otherwise others will do so.

Shifting the Balance of Power (DH 2001) has also brought about new forms of nursing leadership and a change in culture of management and leadership – from Department of Health to the front line. Clinical leadership courses have now been extended to lower grades of staff as the leadership skills of the entire qualified workforce are strengthened through local and national programmes, facilitated and strengthened through the Kings Fund (Kings Fund 2004). 'Shifting the Balance of Power and devolving responsibility', yet there are potential dangers here. Child protection requires tight, co-ordinated and strong leadership. How can roles be developed yet not become a fragmented child protection service? This needs to be explored further and will be the focus of planned future research. Encouragement to pursue this stems from the speech given by John Reid encouraging and promoting 'inspiration and entrepreneurialism' at the Chief Nursing Officers Conference November 2003 and to the winners of the Health & Social Care Awards July 2003 (DH 2003b, DH 2003c). Yet, it could be questioned – at what cost? Would heavily focusing on one initiative be at the cost and use resources meant to be shared with others?

3.3 Managing Change

Constant change since New Labour came into power in 1997 brings to question how organisations manage change. Not only changes within child protection, but also organisational change within NHS particularly related to primary care. Changes within the NHS are never likely to be straightforward and linear. Such far-reaching change cannot occur in a vacuum. There are key internal and external factors the organisation has had to
try and recognise, and acknowledge the principle sources of resistance to change. This elicitaton enables change to be implemented and to create the right climate to which people support change. Resistance to change generally stems from lack of knowledge (information or skills) or through 'emotional reactions' (perceptions and assumptions of the impact of change) as argued by Iles and Sutherland (2001).

Theories proposed by Huy (1999) provide a valuable framework to ascertain how the PCT as an organisation has and is managing change. Applying the literature explored to the PCT suggests that it has acknowledged the importance of 'emotional capability' as an organisation and given consideration to 'emotional intelligence', which will confront the drivers and resisters to change (Huy 1999). It has actively sought to engage all levels of staff in the processes of change through providing formal and informal communicational structures that facilitate 'ownership' and forums for the 'emotional release' and displacement of feelings regarding the change being imposed / suggested. This relationship of organisational and individual support can be equally applied within child protection where at a meso level (i.e. The ACPC, Locality child protection groups); multi-disciplinary networks are forming 'emotionally supportive' structures as a forum to debate and 'come to terms' with the reality of the constant changes (i.e. Impact of Children Bill 2004). It can also act as a bridge for change behaviour between micro and macro levels (Huy 1999). It could be argued that only those who are willing to consider change engage in seeking and attending informational and emotional support networks and that the true resisters to change may remain cynical, demonstrate withdrawal behaviour and possibly prepare to sabotage change (Audit Commission 2004).

Within systems theory, the PCT can be described as an 'open system' (Iles & Sutherland 2001:17). In terms of understanding organisations, systems' thinking suggests that issues, events and incidents should not be viewed as 'isolated phenomena but seen as interconnected, interdependent components of a complex entity'. Applied to the change management that has occurred within the PCT, equilibrium has been maintained through the energy applied to looking at the change as a whole and including all 'players' in the process. Organisation change is a common feature of the NHS but the effects are exacerbated where there is poor leadership and a lack of strategic capacity and direction.
The Audit Commission Annual Report (2004:24) provides evidence and shared experiences of positively managing change and reinforces that 'people often show real engagement' when they are offered opportunities to get involved and have influence on local policy. Hobbs (2004:20) reinforces this and explores an alternative approach to managing change – 'Appreciative Inquiry'; and how it is particularly suited to change management in the NHS.

Changes within local policy were not initially identified and acknowledged within the PCT following publication of national policy guidance in 1999 (DH). This is not the forum to explore the reason for this, however if the policy had been reviewed, it would have identified the wider training needs of the workforce. National policy guidance was reinforced following the recommendations in the Laming Report (2003). Training has been extended to the whole workforce through a mandatory and tiered approach strengthening the focus on multi-disciplinary working and training. Involvement of practitioners (through the Prime Worker system) and organisational stakeholders (through the PCT Board) in the decision-making process of these micro policy changes has facilitated an inclusive approach to the implementation of change. With constant changes, the government and local PCT's must begin to address more seriously the issue of staff retention. The NHS must focus on how they can retain staff as it is one of the greatest challenges the NHS faces. John Reid (DH 2003b), proudly publicised the vast increase in nursing numbers, but it is important to look beyond the figures in the headlines that seem to ignore that the statistics do not reflect full-time equivalent or relate the vast exodus of trained and highly skilled nurses. 'People are fundamental to change – employers ignore them at their peril' (Spellman 2004:7). Spellman explores how planning and implementing change through people can deliver positive effects and gives an example of Frimley Park NHS Trust who focused on 'Investing In People' Standards to aid recruitment and retention. The Kings Fund have also identified this concern and facilitated initiatives to address this (Buchan et al 2003, Kings Fund 2004). Cook (2004:18-19) quotes the Director of Social Services, Haringey:

*One of the most jaw-dropping figures in the Laming report was that 30-40% of children's social work posts in Haringey were vacant at the time of Victoria Climbie's death ...Stabilising staff has been one of the most significant things since Climbie.*
4 Working Together in Policy Communities.

4.1 Policy Communities.

The notion of policy communities is most appropriate in a multi-agency, interprofessional area such as child protection; in fact, it is a requirement of the 'Working Together' policy (DH 1999). The message is unequivocal, however the translation of an agreed rhetoric no matter how well formulated through policy into recognisable interprofessional practice, reality remains challenging – particularly for agencies outside health who over the last ten years also had to try to understand structural and organisational changes within health organisations. To be effective, policy communities require a degree of ideological harmony and reciprocity, however, it has been justifiably argued by Lupton et al (2001:23) that there are also limitations to this ideology, as networks are highly susceptible to 'external pressures and are cross-sectoral and multilevel in nature'.

At a national level, policy responsibilities for children were traditionally shared across a wide and diverse range of governmental departments. The government in the 2004 Children Bill has addressed criticisms of the disjointed approach to childcare policy, and laid down plans to appoint a Children's Commissioner. This will locate responsibility for children and young people (including child protection) firmly and publicly in a single organisational form. However, there are already challenges to this proposed idea of a Commissioner, in that it would not be a truly independent post as first described, and that government would still have strong influences on the ultimate decision-making process, thus defeating the aim of this new post (refer to page 6).

Unlike general child policy responsibilities, The Department of Health has always provided a stable core policy location for development of child welfare and protection policy. This traditionally being a fairly tight-knit 'iron triangle' and fairly exclusive group comprising ministers, civil servants, selected professionals and academic advisors (Ham 1999). Periodically, this small community expanded into a wider intergovernmental network in order to agree specific policy and practice guidelines (Lupton et al 2001). Political reforms of the NHS at the end of the 1980's under the Conservatives effectively ended the 'producer capture' of the health policy process. Working for Patients (DH 1989b)
consolidated the power of managers at the expense of clinicians, moving doctors' organisations from the centre of health policy affairs to the pluralistic margins. This led to degeneration in relations of the four key power groups within the NHS – Politicians, Bureaucrats, Managers and Medics. However, in 1997, the Labour government returned this power to doctors, GP's in particular through the development of primary care (Ham 1999).

With government changes, different focuses on policy community have been identified. With the present Labour Government there is a shift towards using their own policy advisers rather than traditional 'career civil servants' – 'The Third Way'. It could be argued that this has led to disempowerment of the traditional status of some civil servants used to the pluralistic or corporatist approach of previous political parties and certainly loss of the knowledge they possessed. White (2004:25) quotes:

_Labour is awash with promises of power being devolved away from Whitehall... Health Secretary John Reid has apparently already started cutting headquarters staff by a third._

By July 2004 this had progressed further (Healthcare Commission 2004). Perhaps it is time now to give serious consideration to some of Dewar’s (2003) proposals.

At the meso level, the policy community is the ACPC, interpreting and implementing central policy through a multi-disciplinary approach using a detailed framework for 'mandated coordination'. The vision of any government for the future of the NHS cannot be achieved without joined up thinking and working between partner agencies, particularly within the health & social services (DH 2003a). Legislation has enforced this and the mandated changes in the Working Together policy guidance (1999:2) reinforced this alignment. At this level, factors such as multi-organisational and professional cultures, organisational resources and competing policies are relevant. Lessons learnt from inquiries have cemented the developing theory that individuals cannot and should not work alone in the protection of children. Changing policy is one thing; changing behaviour of individuals within a complex system to conform to policy intention is another. The weakness with policy implementation has been judged time after time to be able to effectively apply this
since the fulfilment of any policy agenda and requirements are adequate funding and local commitment:

*Achievement of domain or ideological consensus within the network, effective work co-operation or positive mutual evaluation will be possible only to the extent that it does not involve actions that undermine the position of the collaborative agencies and roles of different players* (Lupton et al 2001:16-17).

This reinforces Harrison's (2001) argument that policies should not only be politically acceptable but also technically effective and it is here that Benson (1983) would argue the importance for the local policy community of understanding that their operation is embedded in, and subject to the operation of wider, political and economic processes and to be successful, consideration must be given to the theoretical dimensions of 'domain consensus, ideological consensus, positive evaluation and work coordination'.

4.2 Working Together.

The Working Together' (1999) national policy framework reflects ideology, yet there are many blocks to effective working that need to be overcome if policy is to be implemented effectively. Sharing information and data protection pose great threats to effective communication. The Bichard Report (2004) was severely critical of the failure in information sharing that allowed Ian Huntley to obtain a job as a school caretaker and calls for better co-ordination between agencies. The Children Bill (2004) was heralded as a breakthrough in providing a clear framework and pathway for information sharing, yet realistically as previously discussed, what has been announced so far provides lack of clarity about how the new information sharing reform will be implemented. 'Working together' across agencies has some way to go to achieve the ideology set out. A colleague Social Worker recently reported to say:

_We work together well when there is a crisis – there is neither inter-agency work on a routine basis or the capacity to deal with issues in a preventative way_ (Owen July 12th 2004).
This demonstrates dissonance in policy delivery, but it is from a practitioner working at the ground level. Birchall and Hallett (1995:213) found that although coordination was mandatory – in reality research showed it was 'less a case of joint working than agreed division of labour'. They also found that providing the organisational arrangements did not in itself guarantee joint working. In order to collaborate effectively, needed to spend time discovering how alike but also need to understand the differences. A shared vision, collective goal setting and a mutual understanding of roles characterize collaborative working. However, collaboration also entails an ethos of power sharing and a commitment to time and effort. Benson's (1983) domain and ideological consensus may also be hindered by different degrees of power or involvement on the part of its participants. Lupton et al (2001:177) argues that it is this that appears to be the biggest area of 'disequilibrium within the local provider networks ... a clash of different organisations paradigms' – systems and accountability. Whilst posing difficulties for practitioners, managers are making notable progress on joint initiatives and policy development locally i.e. domestic violence, locality meetings (linking positively here to achieving Benson's (1983) 'equilibrium across the four dimensions').

The thinking behind the present government policies has generated a renewed commitment to inter-agency working and is embedded in the philosophy of 'The Third way' (Glennie 2003) The main tenet for modernisation of the NHS was replacing the competition of the internal market with co-operation and partnership and with the aim of improving communication and working practices across professions and organisational boundaries. It also challenges the traditional professional elitism that focused organisational power in the hands of medics and managers (Hart 2004). Interprofessional working tries to replace existing power structures through a commitment to equality and collective responsibility. This ideology contrasts with the Thatcher years that tended to focus on efficiency and cost effectiveness which saw 'the emergence of managerialism and marginalisation of nursing' (Antrobus 1997). Yet, caution must be exercised of complacency as policies of the Third Way also focus on cost containment, efficiency and strong central government control. Also, there is a move to ensuring desired policy outcomes of effective collaboration are given consideration other than through legislation (Glennie 2003).
4.3 Inter-Agency Training and Development.

Provision of effective multi-disciplinary training is a key element of national and local policy and high on the list of recommendations from child death inquiries spanning 30 years (Reder et al 1993, Laming 2003). Staff from all ACPC agencies are able to access single full or half day multidisciplinary training organised within the PCT or by the ACPC. However, whilst these training sessions are valuable, it raises questions about the long-term impact of these short sessions on truly understanding other agency roles. A local study undertaken by Smith (2001) looked at the impact on practice of shared learning in child protection. The experiences of ex-students who had completed a two-year multi-disciplinary course in child protection were explored. What was significant to this study was the length of the course being seen as invaluable to the benefits for future practice. Respondents repeatedly reported that facts could be learnt by bringing professionals together on short study days, but that it took time to develop mutual understanding, pooling of ideas, critical evaluation of practice and understanding of own and other professional boundaries and constraints. Also, that the breaking down of barriers and establishing a 'safe environment' for such exploration took time to develop. These issues are key to a co-ordinated approach to the protection of children and relate positively to achieving Benson’s (1983) model of 'work coordination'.

Multi-disciplinary training in the workplace is seen as vital but in reality is not always working well as it is not ‘protected time’. Trying to fit training into work time without back-fill, these sessions are not always well represented by professionals. These findings were reflected in research undertaken by Stanford & Yelloly (1994), Reder & Duncan (1993) and reinforced by Hutchings et al (2003) - that awareness and appreciation of the roles of others is essential for effective collaboration. Yet, there has arisen in the last five years conflict over the governments mixed messages about multi-disciplinary courses such as the one described above. These courses (particularly locally) have discontinued. Underneath the ideology there are two conflicting policies; whereas the government on one hand state how vital it is to work and train together across agencies (DH 1999), another policy from The Care Standards Act 2000 aimed at raising standards in Social Care has made this impossible to achieve locally. From January 2001, there was a new pathway
for social workers in post qualifying training (Child Care Award) for which all social workers working with children should have completed by 2006. This requirement led to Local Authorities putting all their resources and finances into this new training course and which did not allow for staff to attend other substantial training. Therefore as the course would no longer be truly multi-disciplinary, it had to close.

There is widespread recognition at the highest levels of government that achieving ambitious programmes of health and social reform will rely in no small measure on motivated, flexible and well-educated professionals with 'fitness to practice'. Strachan, Chairman of the Audit Commission reinforces this requirement; 'Ultimately, it is people, not structures that make public services excellent' (Audit Commission 2004:2). Therefore multi-disciplinary programmes of continuing professional development that produces independent, reflective practitioners equipped to pursue a process of life-long learning within the scope of child protection is essential and that government ideology expressed through policy (particular 'Working Together') should be made feasible through the provision of the resources in order to achieve this. Linking this to Gunn's (1978) conditions for effective policy implementation; condition 1, 2, 4 and 5 (see appendix) are not being met and there are blocks in the system to achieving Benson's equilibrium (1983).

4.4 The Primary Care Trust Policy Community.

At PCT level, the policy community is the child protection team, Prime workers and PCT Board. They ensure ACPC procedures and individual agency policies and procedures that supplement these documents are implemented. Despite the strength of 'medical power' in the macro policy decision-making community, their involvement, particularly in primary care can be limited. Under The Children Act 1989 and local ACPC procedures, GP's have the same responsibilities as other health professionals; however they are underrepresented within the local child protection network 'community'. Does the reason for this under representation stem from lack of financial incentives or concerns about patient-medic relationships? Difficulties for Doctors to engage within child protection forums may arise due to timings of meetings and conferences (Burton 1996, Lupton et al 2001, Bannon 2003). Further exploration of research into this area albeit important is not
within the remit of this study but will be explored further in future research. The concerns about engaging medical practitioners at a local level are being partly addressed through the new General Medical Services contract and GP appraisal system, which requires them to participate in training. Could someone else represent them from within the Primary Health Care Team (PHCT)? Health Visitors are regarded by some GP's as the child protection 'experts' within primary care (Simpson et al 1994, Burton 1996, Lupton et al 1999, Bannon et al 2003).

In 1997, xx ACPC began to address this through development of the role of 'Prime worker' for child protection within primary care. Commitment to the principles of this role is embedded within the child protection policy of the PCT. The initial idea was the Prime worker would become an important representative of the local PCT policy community and develop and maintain effective communication systems within the PHCT. In 2004 there is developing uncertainty about this role as since implementation in 1997 this role has not been reviewed or audited. New staff in post have assumed the title of Prime worker. A review is necessary to ensure the role meets the purpose highlighted in the policy ideology of Working Together (WS ACPC 2000 Section 8:13). In relation to Benson's (1983) theoretical model, it could be argued that there's a widening gap in the domain (who does what) and ideological (how it is done) consensus.

4.5 Relationship between Core Policy Communities and other Interest groups.

The politically sensitive nature of child protection requires that to be effective and stable, the core policy community operates within a wider network and gives consideration to other stakeholders excluded from the core community i.e. key service users, and professional interest groups. Lupton et al (2001) raises an argument that although both the core and peripheral network groups share the same overall aim of child protection policy, potential or actual conflict may arise around the means of achieving this.

The role of the media in child protection policy development has been significant as over time it has highlighted key issues within society impacting on the welfare of children (Maria Colwell, Sarah Payne as examples). It also sensitises and amplifies concerns raised
to the public who in turn respond with 'public outcry for policy makers to do something', bringing problems which may have previously been outside the present political agenda firmly into the political arena. It also brings criticism of those involved with the child and that the 'State' should have intervened. Consideration needs to be given to any political bias or distortion of the facts that may emerge that influence public opinion at the expense of selling paper / gaining votes. The media may be seen to positively influence societal view, it can also be seen to damage professional judgement and accountability. Recent media focus on the 'Expert Witness' has led to reluctance from paediatricians to become involved in the child protection process (Craft and Hall 2004). Lupton et al (2001) argue that political ideology is often best played out through the newspapers and that specific incidents may be portrayed as illustrating a wider social problem; stereotypes may emerge along with public panic. Media has been powerful with strong influences to shaping the context within which policy responses take place locally as well as nationally.

The government's response to high profile 'inquiries' is often an immediate responsive action aimed at calming public outcry. This can be clearly demonstrated in the response to the death of Victoria Climbie. Policy decisions are often seen as reactive but could they be proactive? Although the government has the ultimate power over policy, over the last twenty years, there has developed a strong influence upon policy from 'pressure and interest' groups. Some of these groups developed from particular high profile 'scandal' cases, but others have developed from interest in the research unfolding. Interest groups and their thinking have a direct and indirect influence on policy and practice:

_A direct influence on individual decisions and practice at the micro level; and an indirect influence in so far as they feed into the policy-making process at a higher level_ (Fox Harding 1991:221).

The present government promotes public involvement, yet how do they gain a place at the table? Shannon (2004) explores the results of a recent Healthcare Commission national patient survey and although results appear positive, the report questions and explores with some scepticism whether patient individual and collective voice will genuinely be listened to, not least because the Commission for Patient and Public Involvement in Health (CPPIH) was axed in July 2004. Kings Fund (2004) shares these
concerns, yet as an established independent voluntary body has gained and maintained influence over some policy decisions and changes through the research and analyses they undertake.

4.6 Accountability and the Child Protection Operational Policy.

Accountability is integral to social and political relationships. It implies a delegation of power by those in authority to those sanctioned to carry out the duty. Historically, principles of political accountability have been - transparency, indivisibility and the power to hold to account (Hunt 2004). This can be applied to all levels of accountability in and outside the political arena. Accountability is at the forefront of the constant changes within the child protection and Working Together (1999) reiterates the development of shared responsibilities. Increasingly the government stresses the need for multiple sources of accountability (Lewis 2004, Checkland et al 2004). Criticism towards the NHS was justified from The Laming Report (2003:5), which concluded 'the principle failure to protect was the result of widespread organisational malaise'. The questions of accountability are high concerning the new Children Bill going through Parliament at this time. These concerns central around clearer lines of accountability needing to be defined than were initially outlined. Also questions and needs to be tested is whether the proposed changes would have prevented the tragic death of Victoria Climbie.

The PCT is at the centre and is accountable in what can be described as upwards, downwards and horizontal levels (Hunt 2004). Downwards, it is accountable to the population served and in this aspect – the best interests of the child must be given paramounsty (Children Act 1989). In this PCT, there is potential for ethical dilemmas to arise, as there is an imbalance of over 65’s and even over 75’s to children. Yet are resources evenly spread? The PCT Board, and the Professional Executive Committee (PEC) provides the formal structures of accountability within and outside the PCT. Commitment to the values of accountability (Hunt 2004) can be seen as ‘transparent’ by the Board holding their meetings in public and through publication of Annual Reports and Business Plans. Patient and Public Involvement at PCT Board level (according to the Labour Government) should ensure local people are involved in any decision making process.
However, in reality it often questions the choice of representative being a true representative of ‘the general public’.

In the climate of constant change and Modernisation, plans are in progress for commissioning responsibilities presently undertaken by PCT’s to be devolved to Practices (Lewis 2004). The impact of this is yet to be fully explored but there are likely to be dilemmas, particularly in finding a balance between the needs of primary care clinicians to:

*Feel free to innovate and be entrepreneurial and that of the PCT’s to plan systematically and to improve equity of access to services among their patients (Lewis 2004:18).*

Although initially resistant, NHS Alliance supports this move (Dixon, 2004).

Upwards they are accountable to the Strategic Health Authority (SHA) to ensure that structures are in place to support and implement the policy directives both nationally and locally. This includes identification of lead professionals (Named Doctor and Nurse) to lead and take forward child protection responsibilities. Focus on quality, drives and delivers the modernisation agenda of the Labour government and has seen the devolving of and increasing accountability given to PCT’s. John Reid MP has outlined parameters for further reductions in Whitehall’s bureaucracy (Healthcare Commission 2004). Whilst this has been welcomed and allows for local delivery plans to be implemented, sceptics could argue that this could be viewed as Politicians seeking to avoid responsibility – as have they not lost many of the core stable policy maker civil servants and with it the knowledge? (Lupton *et al* 2001). The PCT and The SHA are accountable directly to the Department of Health who in turn are accountable for the distribution of resources to support the PCT. As mentioned, this is a potential area of conflict and concern where demand for resources out weigh the availability as clinicians ‘barter’ with the PCT for funds to meet the requirements of a variety of competing policies and National Service Frameworks. Yet, the government are not slow in initiating further policy directives. The Audit Commission’s role is to provide high quality local and national services to the public and provides tools and Reports highlighting best practice (Audit Commission 2004). Governments are authorised to exercise power on behalf of the people and are held to account through the electoral system.
In one direction laterally (Hunt 2004), The PCT is accountable to the ACPC as they are signatories to the multi-agency child protection procedure document. Here, Agency conflict may arise due to the commitment of time and financial resources different agencies are able or willing to give. It brings into question who should sit at the ACPC table – managers who can commit resources or clinical specialists who have the subject knowledge? In the other direction, The PCT is accountable to the workforce. This includes the entire workforce, clinical and non-clinical irrespective of their role with children. This includes structures to be in place to support and supervise staff in their role in the protection of children and ensure that a tiered approach to training needs are developed and implemented. The present PCT policy addresses this.

Within the PCT, individual practitioners are also accountable, dependent on their role and responsibilities as laid out in their job description. Practitioners are front line executers of policy and their clinical decisions have important resource and management consequences:

*Those in senior positions in organisations carry on behalf of society, responsibilities for the quality, efficiency and effectiveness of local service... a yawning gap... the fault of managers because it was their job to understand what was happening at their front door* (Laming 2003:5).

Professional accountability is a central pillar in the construction and maintenance of an autonomous profession; therefore professionals are accountable to their professional organisation i.e. Nursing & Midwifery Council, General Medical Council through a system of specific professional codes and a system of professional accountability. Professionals are also accountable to their peers dependent on their role, to ensure safe and best practice is observed and disseminated.

Accountability is at the heart of the concept of clinical governance. Clinical governance provides the framework for quality improvement. The lynchpin for the quality agenda of the present government was a succession of government papers with 'a new vision' for the NHS with 'quality and accountability' as the guiding principles (DH 1997, DH 1998, DH 2000b). Systems are in place through the Commission for Healthcare Audit and Inspection (CHAI) to monitor standards and inspect PCT’s, particularly at present in relation to
Laming Report recommendations (2003). The Government has used 'transparency' as a means of holding organisations to account through the publication of league tables and star ratings. Performance Indicators for child protection have been introduced into performance ratings and this is facilitated by giving clinicians the tools necessary to compare practice and improve care (Healthcare Commission 2004). Locally, this is achieved through the CHI Audit group, Audit Assessment Tools, PCT Board and Clinical Governance Department. The National Service Frameworks (DH 1998) provides the structures to set and maintain national standards and the publication of the full document NSF for Children is imminent.

There is a shift towards accountability based on surveillance and rules. This raises the question that whether concentrating upon measures to increase confidence in the quality of the services offered may have dysfunctional consequences. For example that performance targets are being privileged above all else with the de-prioritisation of aspects of practice that are not being measured. There is also the possibility for manipulation of statistics and targets to meet requirements. A key recommendation of the Laming Report (2003) is proposals for new structures that will increase accountability in child care services. However, it is not apparent how increased accountability will serve to improve the quality of Practice and it's Supervision:

_The danger is that tighter structures for scrutinising and monitoring child care work will result in procedures rather than on practice capacity to engage with families (Stanley 2004:76)._ 

It must be acknowledged that the prime people accountable to children are the ones who have parental responsibility. However, the State is accountable to intervene when they become aware that parental responsibility is not being adequately met and that the welfare of a child is at risk of significant harm. The decision when to intervene is often not an easy decision. Article 8 of The Human Rights Act could be viewed as in conflict with the Children Act 1989. There needs to be a balance between interference 'in family life' and protection. What is 'good enough parenting'? Often professionals working towards the same goal conflict (Lupton et al 2001). If accountability within one's own profession is hard, the challenges of accountability whilst working across different agencies and
professions is more challenging. It brings with it professional ideology, boundaries, values and attitudes which can get in the way of effective decision making and ultimately could impact on the welfare of the child.

5. Conclusion.
5.1 Reflection.

This policy analysis and in formulating a conclusion has left many questions unanswered. While it is clear that only a very small proportion of children subject to child protection interventions ever experience the types of harm and injury which typify the cases which have captured the imagination of the media and have been subject to public inquiries, there is no doubt that it is the 'heavy end' cases that have driven policies and procedures and influenced day to day practice and decision-making. Since 1997, the Labour Government appear driven to bring about change yet such prolific changes within the NHS and particularly within primary care has allowed very little time to settle down and truly reflect, stabilise and consolidate. Certainly there has not been time to become complacent about what is working well. Child protection policies will never be permanently fixed as national and local policy is driven by the legislative requirements of 'the best interests of the child'. This means constant review of policy and procedures in light of new evidence. It is this shift to research underpinning practice that has brought agencies working closer over the last fifteen years and been applied to formulate multi-agency practice tools and procedures.

With the 2004 Children Bill imminently to become an Act, it is within a constant period of change and future uncertainty for the precise direction of future policy that will impact on the welfare of children and the collaboration of those working in a child welfare environment. At present, many amendments to the Bill are being sought and debated and once finalised will take time to implement in order to change practice. The new Act will provide the legislation to the changes identified in Every Child Matters (HMG 2003) and Every Child Matters: Next Steps (DfES 2004b). Already some of these changes are being implemented for example bringing together of children's services under one Governmental department – DfES, by appointing a Minister for Children and Children's Trust pilot sites.
Other proposals leave clinicians with uncertainty – particularly relating to how Information Sharing will be implemented, funded and data protected. The move to a Safeguarding Board as opposed to ACPC has still not received clear guidelines as to how local provider networks will operate and the power and accountability that they will hold.

The researcher has observed that changes have led to strengthening of local policy networks. These networks are by necessity a multi-disciplinary forum whether at ACPC or Locality level. The time from the proposed changes to implementation has allowed agencies to explore and debate the possible impact and foresee how these can be implemented locally to meet identified need.

Xx is privileged to be one of the first Children Trust Pathfinder sites and is already implementing some of the proposals laid down in ‘Every Child Matters’ (HMG 2003) and ‘Next Steps’ (DfES 2004b) particularly in respect to ‘Joint Access Teams’. It is only six months since the pilot started and evaluation is therefore limited but has begun. It is the beginning of pooling resources (financial and people) to improve the experiences of children and avoid fragmented childcare services. The future may give more power to Education Services, as already the Government has plans to extend nursery provision to two years olds and Children Centres and Extended Schools are likely to be based within educational establishments. However as yet, it is not clear who will manage and lead these Centres.

5.2 Impact on Service Delivery.

In primary care, the changes are just as prolific. It is two years since the formation of the PCT, now discussions about devolution of commissioning to GP Practices are underway (Lewis 2004). Already the GMS contract has impacted on child protection in primary care as one of the requirement is to provide child protection policy guidance. This has been facilitated within the PCT by the Named Nurse as an opportunity to raise the profile of child protection in GP surgeries and to try to engage them whilst also working towards ensuring robust systems are in place not only to meet the requirements of a GMS inspection but also the child protection policy and ultimately to provide appropriate
responses to concerns about children in need. The present operational policy has certainly impacted on service delivery. It is the first child protection policy sanctioned by the PCT Board. The policy has been disseminated, as it is now a mandatory requirement for all staff to attend basic awareness training. This has impacted on the resources of the child protection team to provide this training as well as the tiered level approach to training for staff who work with children as laid down within the policy. The policy has also been used as a vehicle to promote the role of The Prime worker.

Working Together and collaboration must be the foundation of any child protection policy nationally and locally. The national changes are designed to strengthen this and locally a strong and committed ACPC and Locality are working towards these goals. Collaboration is mandatory within the Children Act 1989 and it must continue, despite recent research that explores collaboration is as much to blame for the death of Victoria Climbie (Parton 2004). There is still a long way to go to effective working and learning together and research will continue and practice will be modified. This study has highlighted a gap in the knowledge and understanding of the role of the Prime worker and it’s ‘value’ within the PCT, that needs to be and will be further explored outside the remit of this study. The xx ACPC procedures and operational policy acknowledge the Prime worker as having a ‘pivotal role’ in facilitating communication and supporting staff within primary care – ‘at the coalface’. This was following three case reviews that identified an urgent need to provide a more effective support to GP practices across the county. So what is the role of the Prime worker and who is the best person to undertake this role? The role has not been formalised or specific training given to the role. The role of Prime worker was instigated in 1997 but in 2004 is there evidence that practitioners have really ‘signed up’ to the role; ‘have we brought them along with us’? Since 1997 the role has not been evaluated or audited. As staff members leave another nominated Prime worker replaces them. It is unclear to some not involved in the initiative at the outset, exactly what their role is.

If Prime workers are to become the ‘champion’ within primary care in respect of child protection as outlined in PCT policy, then urgent consideration must be given to exploring why this role has been allowed ‘to drift’. Does the problem stem from lack of ‘ownership’? Is it a role supported at a strategic (Strategic Health Authority, PCT Board) as well as
practitioner level? How far will the PCT support the development of this role and should it be re-launched to raise profile and strengthen policy? What do other counties do? A role traditionally designed for GP's but does it need to be?

Sarah Mullaly (DH 2004a) reinforces and strengthens the role nurses, midwives and health visitors have in working with vulnerable children and families and makes recommendations for the future role for nursing in her response to the publication of 'Every Child Matters' in 2003. Many of these recommendations could be taken forward within primary care through the role of the Prime worker. In developing the role it is in line with the ethos of modernising and developing primary care including time to 'liberate the talents'. John Reid (DH 2003b) empowers nurses and states:

_The challenge is how to free you from old professional turf wars...to liberate you from the remnants of the old ways of thinking...the answer I think is to encourage a new generation of entrepreneurial nurses._

5.3 Recommendations to take forward.

This study has provided the policy context to take forward recommendations for practice.

I. A Service Development Project, which will involve undertaking a baseline audit of the role of Prime worker (as it is now), which will be used to set standards for the role which can then be measured.

II. Research project using Q-methodology (phase 1) to gain insight at a strategic level into the 'ownership' of the role of the Prime worker through ranking existing perceptions of the value of the role and who would be best suited to undertake this role. Exploration (phase 2) of the systems in place within other PCT's to support staff within primary care in relation to child protection.

5.4 Conclusion.

There is no room for complacency in child protection. There is always a need to be vigilant to the need to change and enhance the systems in place to protect children. This study has reviewed and evaluated the PCT child protection operational policy within the framework of the statutory national policy guidance and policy community, and local policy provider networks. Influencing drivers and resisters to effective implementation have been explored and critically evaluated in the context of the impact on service delivery. Clearly
there needs to be strong leadership and commitment to child protection within primary care whilst also acknowledging the time restraints and 'multiple roles' of practitioners. Knowledge and understanding of child welfare and policy has evolved and developed over time, informed by research, experience and critical scrutiny of practice. It is now time to take this further forward into the primary health care setting. PCT's must recognise that their goals whether delivered through policy or reports can only be successfully achieved by engaging fully with clinicians 'at the front line'. The philosophy of 'The Third Way' requires that the nursing profession contribute on the basis of its skills, talents and experiences. Where are the children in all this? The answer is simple – they must remain central to any policy or procedural change – 'Best Interests':

*Entrepreneurial nurses take the initiative creating and implementing new ideas. They can handle uncertainty and manage risk. They value autonomy and deal in networks and team working* (John Reid MP, Chief Nursing Officer Conference, 14th November DH 2003b).

I support and embrace John Reid's concept of entrepreneurial nurses and strive to provide strong clinical leadership in my specialist field of child protection and 'make a difference' by taking the proposed recommendations forward into practice.
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Doctorate of Clinical Practice / Policy Analysis/ October 2004


Doctorate of Clinical Practice / Policy Analysis/ October 2004


Doctorate of Clinical Practice / Policy Analysis/ October 2004


## CHILD PROTECTION OPERATIONAL POLICY

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CHILD PROTECTION OPERATIONAL POLICY

Purpose

XX Primary Care Trust is committed to the promotion of children’s welfare and to protecting them from abuse and neglect. The purpose of this policy is to provide a framework that describes the systems in place that will enable this. The overall aim is that staff will be aware of their role in protecting children and provide the framework for development of competence and confidence in this role, and for support in order to achieve this.

The principle legislation for all decisions concerning the care and protection of children is the Children Act 1989. Working Together to Safeguard Children (DH 1999) sets out how all agencies and professionals should work together to promote children’s welfare and protect them from abuse. XX Area Child Protection Committee (ACPC) provides the procedures from this document that guide those members of staff working within XX. XX PCT acknowledges the importance of staff receiving adequate training and supervision to ensure that the needs and welfare of children are paramount.

Scope

This policy applies to all staff working within XX PCT.

'All those working in the field of health have a commitment to protect children... All Health Personnel, including medical, nursing, therapy, counselling, reception and administrative staff will adhere to the XX procedures' (XX ACPC).

Responsibility

The Child Protection Team within XX PCT are responsible for the implementation of this policy and that staff are fully conversant and comply with the requirement of this and other related policies to the protection of children i.e. supervision, training.

The Child protection Team are responsible through the Director of Community & Intermediate Care to The PCT Board.

Dr. XX
Named / Designated Doctor
Consultant Paediatrician
Tel:

KT
Head of Health Visiting,
School Nursing & Child Protection.
Tel:

CH
Clinical Nurse Specialist
Child Protection
Tel:

LS
Named Nurse for Child Protection.
Tel: Requirements

Doctorate of Clinical Practice / Policy Analysis/ October 2004
There is a tiered approach to child protection training within the PCT. It is mandatory that all staff within the PCT attend the 'Basic Awareness' training session. The level of further training and update required is clearly defined within the Child Protection Training Policy.

**Supervision.**

All staff within XX PCT will have access to child protection supervision through the Child Protection Team and Prime worker network. Members of staff whose work brings them into direct contact with children and families will have access to regular structured supervision. This is clearly defined in the Child Protection Supervision protocol.

**Prime Workers network**

Each General Practice Surgery has a named Prime worker for Child Protection. The role of the Prime worker is to facilitate communication and to provide front-line support and guidance to staff within the practice.

**Audit standards and criteria**

This policy will be monitored through The Prime worker network, Personal Development plans, Clinical Governance, Quarterly training reports, Clinical Supervision and the annual Child Protection Report.

**Reference documentation**


XX Child Protection Procedures (2001) XX ACPC.

Doctorate of Clinical Practice / Policy Analysis/ October 2004
Appendix II

Gunn’s conditions for ‘perfect implementation’ adapted for ‘evidence-based medicine’.


1. Sufficient material resources in the appropriate combination available – beyond money, skills or shortages.

2. Sufficient non-material resources – ‘real-world organisations have ongoing activities and other priorities with which new policies have to compete for attention.

3. That the policy to be implemented is based upon a valid theory of cause and effect.

4. The relationship between cause and effect is direct and that there are few, if any, intervening links – ‘reminds us that most organisational endeavours require the cooperation of teams of individuals, and that the more links in the chain, the more likely it is that at least one will break down.

5. The external dependency relations are minimal – ‘refers to political factors such as the refusal of other organisations to cooperate in implementing the policy.

6. That there is understanding of, and agreement on objectives of the policy and how they are implemented throughout the organisation: that is, that there should be no conflicts within the implementing organisation and that everyone should clearly understand what they have to do and when. This condition reminds us that organisations are frequently characterised by resistance, conflict disagreement and misunderstanding.

Doctorate of Clinical Practice / Policy Analysis/ October 2004
Benson's Model of Interorganisational Policy Analysis


'The four key dimensions of equilibrium'

1. Domain consensus -
   - Agreement regarding the appropriate role and scope of each agency.

2. Ideological consensus –
   - Agreement regarding the nature of the tasks faced and the most appropriate way of approaching them.

3. Positive evaluation –
   - By workers, in one organisation of the work of others.

4. Work coordination –
   - Alignment of working patterns and cultures.
SERVICE DEVELOPMENT PROJECT

April 2005
AN AUDIT OF THE ROLE OF THE PRIME WORKER FOR CHILD PROTECTION IN ‘XX’ PRIMARY CARE TRUST.
Contents.

**PowerPoint Presentation:**

Slide 1 - Title

Slide 2 - Title and Rationale for Service Development Project.

Slide 3 – Aims of the Project

Slide 4 – Guiding Principles.

Slide 5 – Process.

Slide 6 – Results.

**Presentation of Results:**

1. Prime Worker Questionnaire.

2. Primary Health Care Team Questionnaire.

**Report.**

**References.**

**Appendix.**

I Copy of letter to Prime workers.

11 Copy of letter to Primary Health Care Team member.

111 Framework Protocol and Outline Standards to the role of Prime worker.

1V Benson’s (1983) Model of Inter-Organisational Policy Analysis.

V Gunn’s (1978) conditions for ‘perfect policy implementation’. 
AN AUDIT OF THE ROLE OF THE PRIME WORKER FOR CHILD PROTECTION IN ‘XX’ PRIMARY CARE TRUST.

An Audit of the role of Prime Worker for Child Protection within Primary Care for ‘XX’ Primary Care Trust.

Rationale:

The role of Prime worker for Child Protection was introduced into the county in 1997. This was following several Case Reviews which identified an urgent need to provide more effective support to GP surgeries across the County. This innovation was strengthened by research undertaken by Burton (1996) whose clear recommendations were "To identify a key child protection professional within the practice... to whom others will refer for information" (p46). The health visitor was thought to be the most appropriate person to undertake this role. Objectives were set for this role and disseminated to a nominated health visitor in each practice. It was anticipated that the Prime worker would develop and maintain effective communication systems within the Primary Health Care Team (PHCT).

Although this role was launched with some profile and local media coverage, locally it has never been formalised, evaluated or audited. The Area Child Protection Procedures (2000) are based on the Policy document ‘Working Together (DH 1999) and state “Each GP practice will have a named Prime worker” (ACPC 2000 Section 8:13). Commitment to the principles of this role is embedded within the Child Protection Operational policy of the PCT (Smith 2004). The PCT has a nominated prime worker, therefore has reached 100% requirement as stated within the document. However, there are no Standards by which to measure this role.

In 2004, anecdotal evidence from practitioners undertaking this role, raised concerns and it appears that there is some confusion and developing uncertainty about this role. New staff in post have assumed the title of Prime Worker without induction or training.
An Analysis of the PCT Child Protection Operational Policy (Smith 2004) highlighted a gap in the knowledge and understanding of the role of the Prime worker and it’s ‘value’ within the PCT. A recommendation of this analysis was to undertake a Service Development Project.

The aims of this project are...

- A Baseline Audit describing the role of the Prime worker as it is now, which can be used to set standards for the role of the Prime worker that can be measured.
- To review the current system of Prime worker via the quality assurance cycle of monitoring, measuring and evaluating practice against a set of agreed criteria, in order to provide a high quality child protection service to families within XX PCT.
- To provide data for a larger in-depth study into the role, function and value of the Prime worker for child protection from an organisational perspective.
Guiding Principles:
As embodied in the XX Child Protection Procedures.

- The welfare of the child is paramount and children are entitled to protection from abuse, neglect and exploitation.
- Each GP practice will have a named Prime worker for child protection.
- Members of the Primary Health Care Team (PHCT) will work together constructively with personnel from different agencies.
- All members of the PHCT will adhere to the XX Child Protection Procedures.
- In child protection work the degree of confidentiality will be governed by the need to protect the child.
- Members of the PHCT need to work openly and honestly with parents to achieve a maximum level of partnership and therefore better outcomes for the child.
PROCESS:

- Time frame of Service Development project:
- Size of study and data collection:
  All 24 GP practices in XX PCT. Two questionnaires...
  2. Random sample of other members of the Primary Health Care Team (N=80) to gain a perspective of the perceived role of the Prime worker.
- Consent was obtained from the Director of Community and Intermediate Care in order to undertake this project. From the respondents through returned questionnaires.
- Validity and reliability of the process was monitored and supported through the Clinical Audit Support Unit. The project will be reported through the Clinical Audit Team via the Professional Executive Committee (PEC) to the Trust Board. Recommendations of this project will also be disseminated through the Prime worker system and Annual Child Protection Report.
- Anonymity and confidentiality of all participants was assured. It was not possible to trace any respondent back to any particular PHCT as this information was not requested or required.
RESULTS:

24 Questionnaires were sent to Prime workers. 19 were returned (86%)

80 Questionnaires were sent to members of the PHCT. 55 were returned (69%)

- Data was collated via an Excel spreadsheet, allowing data to be analysed by question number or individual’s response. A summary data sheet was constructed that allowed an overview of the results as this was not easily obtained via spreadsheet alone.

- The results from the two questionnaires remained separated until analysis. The summary data sheet was transferred onto the questionnaire and graphs inserted to facilitate viewing of the results (see appendix / handouts).

- Draft Standards and a protocol have been written for the role of the Prime worker using the data provided and with reference to the research undertaken by Burton (1996), existing Prime worker objectives and ACPC procedures (see appendix / handouts). The key findings will be presented, discussed and debated with the existing Prime workers and ultimately written and sanctioned through the PW forum.
The analysis of the PCT Child Protection Operational Policy (Smith 2004) highlights that in relation to Benson’s (1983) theoretical model of policy analysis, it could be argued that there is now a widening gap in the domain consensus (who does what) and ideological (how it is done) consensus. In relation to Gunn’s (1978) conditions for ‘perfect implementation’ of policy, it would also appear there is some dissonance within the organisation to meeting the conditions described in order to be effective. This will form the foundation for a larger and more in depth study into the role and value of the Prime worker as perceived by ‘the organisation’.

Please refer to copies of the letters sent to the 22 Prime workers and 80 members of the PHCT,

The random sample of PHCT members were selected by sending each Practice Manager a letter and 3-4 envelopes containing the questionnaires. They were asked specifically to ‘please can you give a letter to a GP’ or Practice Nurse / Community Nurse / Counsellor / Clerical or Reception staff etc.

The letter to the Prime worker also outlined that members of the PHCT were being sent a questionnaire. This was to ensure that they were fully informed of the process and reassured that the results of the study could not be traced back to any particular team.

A questionnaire was deemed to be the most appropriate method to collect the baseline data required with a mix of open and closed questions. Using a questionnaire is an efficient method to reach the number of responses required (Robson1993). It also allows total anonymity of the respondent and hopefully more honest answers. This needs consideration when the researcher is a senior member of the child protection team and other methods i.e. interviewing or focus groups may have lead to a biased response. Close scrutiny of the process by the Clinical Audit Support Unit in the use of questionnaires ensured a clear and systematic, well documented and provided safeguards against insider bias and misinterpretation of the results.
RESULTS 1

Prime Worker Questionnaire (anonynmised)
(Please circle one response per question)

1. How long have you been a Health Visitor?
   - Less than two years
   - 2-5 years
   - 5-10 years
   - 10+ years

2. How long have you been the Prime Worker in this particular post?
   - Less than a year
   - 1-3 years
   - 3-5 years
   - 5-7 years
   - 7 years +
3. Were you a Prime worker when this role was established in 1997?

Yes  N= 10  No  N=9

4. As a Prime worker, did you receive any training to this role?

Yes  N=6  No  N=13

If yes, please comment on level and type of training received.

- Verbal. Short explanation of role expectations.
- Some training sessions and guidelines were compiled.
- Whether training at initial launch.
- Study session – basic.
- Initial launch.
- Child Protection training on-going in the Trust.
- Not apart from being at the launch.
- Zero.
- Seminar when this was launched and Prime Worker meetings.

5. How clear are you about the role of the Prime worker?

Very clear  N=3  clear  N=10

unsure  N=5  confused  N=1

6. Is the role of Prime worker on your present job description?

Yes  N=3  No  N=16

7. Do you receive any on-going education or financial support in order to undertake this role?

a) Financial support

Yes  N=0  No  N=19 (100%)

b) On-going training specific to the role (not including the PW meetings).

Yes  N=0  No  N=19 (100%)

8. Have you seen a copy of the XX PCT Child Protection Operational Policy?

Yes  N=13  No  N=6

9. If training opportunities were developed specific to your role as Prime worker, how would you anticipate this being available?

½ Day Training  1 Day Training  Longer
1. If longer, please specify:

- 1 day 1-2 times a year and support group for issues arising.
- Initially 1+ days at least annually.
- I think it merits considerably more attention and underpinning.

10. Do you attend meetings with other members of the Primary Health Care Team where you are based as a Health Visitor?

Yes **N=13**  
No **N=6**

If yes, how often?

Weekly **N=2**  
Monthly **N=6**  
Less frequently **N=5**

Q. If yes, how often?

No response **N=6**
11. If you attend PHCT meetings, is there the opportunity in which to liaise & disseminate information relevant to child protection?

Yes N=11  No N=4  No response N=4

12. Do you have a copy of the Objectives for the role of the Prime worker?

Yes N=7  No N=10  No response N=2

13. How many Prime worker meetings have you attended in the last 12 months?

All N=0  most N=17  none N=2

14. Please describe what you understand about the role of the Prime worker

- Liaise with Practice. A focal point for CP issues, dissemination of information. Aiding the PHCT to keep updated with CP issues.
- Raise the profile of CP issues. Act as a resource for Practice staff who have concerns about any child registered here.
- A focal point for child protection issues and information. A responsibility to keep PHCT up to date although Health Professionals have their own accountability.
- They are a strategic link person within the PHCT for communicating child protection concerns within the team, and interagency. They have an advocacy role for parents, carers and children to work towards maximizing best outcomes for vulnerable children. There is a strong potential for on the job education and training cross discipline.
- The key person within the Practice to coordinate CP procedures. To feed new information back to the Practice and take issues forward. Responsible for maintaining a list of children on the Register / LAC and children of concern.
- Reference person re CP issues. Disseminator of appropriate literature. Coordinator of the surgery personnel re information on CP issues.
- Primarily to liaise and pass on with other members of the PHCT in my Practice area anything relating to child protection.
- Link between GP Surgeries, Social Services and families. Awareness raising role.
- To be the facilitator within the PHCT to ensure the children on ‘cause for concern’ list are known by members. To act as resource. To investigate good working practice. To keep up to date with latest research.
- To collect and collate information regarding children at risk / CPR from other PHCT members.
- Keeping child protection on PHCT agenda. Updating PHCT on CP issues. Recent team response to Laming.
- Taking a lead in the Practice Team for all aspects of CP. Informing staff and educating of new issues. Putting alerts on the computer system. Acting as a link for communication.
- Develop and maintain effective communication within PHCT in the context of child protection. Information sharing, discussion within the Practice. Sound planning. Provide support for staff within the team. Promote and liaise with other agencies Coordinate information flow. Good preparation and Report writing for Conferences.
- Link with GP Practice. Liaise with GP’s where families with CP concern. Up to date knowledge of CP.
- To act as a resource. To provide support. To be a Coordinator for CP in the Surgery.
- Child protection liaison with GP Practice and other members of the PHCT.
- Point of contact and communicator about CP issues for all PHCT members.
15. Do you believe this role is valued?

Yes  N=10

No  N=9

Comments please:

- From the outset, its importance was never made clear, including to Prime workers themselves.
- At a recent PHCT meeting the Practice workers were asked 'how do you find communication with other agencies?' Several of the GP's said it was no problem because usually health visitors dealt with the concerns (strengths and weaknesses to this attitude!).
- Don't think there is a wide understanding of the role.
- Role not understood.
- Am approached by Receptionists from time to time when they have concerns.
- I feel that other members of staff — GP's / Receptionist / Practice Nurse will discuss issues of concern with me.
- Coordinator in the PHCT. Awareness of all current CP practises.
- Practices still remain ignorant about the role even when it is reiterated. One Practice paying a private company to do training when they could use me!
- Maybe this is because I do not feel totally confident with this role. No training, not been Health visiting 2 years.
- Not understood by Practice members. Some Practice Staff don't recognise their role in CP.
- Beginning to be valued by PHCT as I'm putting CP on agenda at each clinical meeting.
- Not valued as specifically appropriate at this Surgery.
- Could be improved.
- I think it is important that one person should coordinate all the above (as stated in Q14), but would do this without the title of Prime Worker as I'm in a stand alone position.
- GP's reluctant to engage and discuss vulnerable children in Practice.

16. If you had a choice, would you prefer someone else to undertake the Prime worker role?

Yes  N=8

No  N=11

If No, why?

- I would like other members of the PHCT to take responsibility but experience tells me that this would not happen. At least Health Visitors are committed to CP.
- No one would be prepared to take responsibility. Practices feel CP is the HV's job!! Still don't understand its everyone's responsibility.
- Most appropriate.
- We have regular CP updates, work within that arena, also we have supervision therefore support in CP work.
- Health Visitor's understand the role.
- Although the HV is the obvious choice, with changes of staff this can be difficult.
- Caliber of colleagues.
If Yes, who?

- GP N=1
- Practice Nurse N=0
- Another Health Visitor N=3
- Other (please specify) N=1

- Specific liaison personnel.
- ?? Practice Manager.
- Person with the most interest in CP not necessarily always the HV.

17. In your opinion, should this role be

a) Continued
   - Yes N=16
   - No N=1
   - No response N=2

b) Developed
   - Yes N=15
   - No N=1
   - No response N=3
Comments please on how the role could be developed / changed:

- Specific training, marketing / promotion of the role (2)
- Clear guidelines on aims, objectives of the role and of responsibilities (2)
- Better marketing and promotion of the role.
- Regular training for Prime Workers.
- Just more informative discussion of the expected role.
- Raise profile including acknowledgement in job description. Articles in CP newsletter and names?
- If it is to be continued I think it should be developed so that the HV undertakes some training for the role of PW with support and updates.
- Possible specialist nurse role in each team to work across surgeries in the team area. Would depend on whether the role also requires in depth knowledge of the families.
- With sharing of good practice, I need to give it more time to feel I am doing the job properly.
- Job management support.
- Any moves that will decrease our sheer amount of duplicated paperwork currently done.
- Any time saving ways of increasing efficiency with communication.
- Protected time for innovative training for the rest of the team. Inspirational ideas / reading / encouragement from senior PCT members.
- A sense that they are interested and will support good ideas.
- Support for some corporate on-going research – Service Users included. Already clear from own small research.
- Depends upon the PCT and others will.
- Training (2)
- We need regular ½ day training on CP – especially important if we rarely come up against actual cases.
- Rolling programme of training using electronic systems of communication.
- Communication to disseminate information across the Practices.
- Recognition of role in job description.
- It needs to be someone the GP’s will liaise with.

THANK YOU. Please return this questionnaire in the envelope
RESULTS 2

Primary Health Care Team Questionnaire (anonymised)

(please circle one response per question)

1. What is your role within the Primary Health Care Team (PHCT)?

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>14</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>3</td>
</tr>
<tr>
<td>Community/District Nurse</td>
<td>5</td>
</tr>
<tr>
<td>Clerical/Admin/Manager</td>
<td>4</td>
</tr>
<tr>
<td>Other (please state)</td>
<td>24</td>
</tr>
</tbody>
</table>

2. How long have you worked at this Practice / Medical Centre / Health Centre?

<table>
<thead>
<tr>
<th>Experience</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>N=6</td>
</tr>
<tr>
<td>1-5 years</td>
<td>N=17</td>
</tr>
<tr>
<td>6-9 years</td>
<td>N=12</td>
</tr>
<tr>
<td>10+ years</td>
<td>N=20</td>
</tr>
</tbody>
</table>

3. At your workplace, have you heard there is a Prime Worker for Child protection?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
</tr>
</tbody>
</table>
If yes, please continue.

If No (N=14), thank you very much for agreeing to complete this questionnaire. These are the only questions that you need to answer.

Please return the questionnaire in the envelope provided.

4. Do you know who is the Prime worker for the Primary Health Care Team where you work? (please do not name)

| Yes  | N=35 | No  | N=6 |

5. Please could you describe what you understand about the role of the Prime worker for child protection within your PHCT? If you are unsure, please do not ask anyone else.

- Someone I would speak to if I had concerns about a child’s welfare. N=15
- To follow up / co-ordinate any child protection concerns passed on to them. N=3
- Liaison with child protection officer / other agencies. N=4
- Arranges / undertakes training for staff. N=4
- Is a resource / support for other team members. N=6
- All aspects of health and social care of all children particularly those identified at risk.
- To disseminate latest best practice advice to other members of PHCT. N=5
- A person with knowledge and / or experience of child protection gained from special / specific training. N=2
- Documents on the computer those at risk so patient and members of family can easily be identified.
- To lead on child protection problems in the community / responsible for. N=2.
- A designated person within the medical centre to turn to for advice.
- To safeguard the protection of children from accidental and non-accidental incidents.
- To be aware of any child at risk registered with the practice. To keep contact with the family and to alert other services / key workers.
- To protect child and siblings from harm. To help family in the same way.
- The prime worker helps to develop procedures.
- To co-ordinate a team response.
- If new babies or new children to the area register with our surgery, we would inform her.
- Point of first contact and advice. N=4
- Holds the child protection manual (one of them).
- A point of reference. Someone I could ‘hypothetically’ get advice from.
- Responsible for maintaining up to date list of children on ‘at risk’ register and updating other members of the team about changes to list, procedures.
- Single person to make certain child protection issues can be addressed.
- Co-ordination and communication.
- She will ensure all procedures are in place effectively.
- Keep relevant personnel updated and fully informed.
- The role of the PHCT is to make sure the child is in a safe environment from physical, emotional harm or neglect. It all counts.
- My background is health visiting and school nursing so have a wider understanding than most … Prime worker = support, liaison, advice, help in case conference work, renewal of notes, help in report preparation etc.
- To monitor children and their families for child protection and other social problems. Those both known to her and referred by other members of staff.
6. Have you ever liaised with the Prime worker on any aspect regarding the welfare of a child?

Yes N=22  No N=18  No response N=1

7. How could / do you access the Prime worker for child protection?

- Discuss with health visitor / another health visitor in PHCT. N=4
- Approach her in her office / Face to face. N=15
- Verbal communication or message on pad.
- Contact them and arrange discussion or if necessary telephone or internal e-mail. N=14
- Contact them and arrange discussion. They are based in the same building. N=7
- Unsure at present but would ask GP / Practice Manager. N=2
- Responds to concerns raised within the same workplace.
- Patient’s notes / EMIS.
- By telephone or verbally to the Health Education Department within the medical centre where I work.
- No problems with communication.
- As and when.
- Telephone her if urgent.
- Primary Health Care Team meets.
- Directly or via Practice Manager or via Counselling Manager or PCT.
- Ask any other member of PHCT.
- Telephone or letter.

8. Does the Prime worker attend Practice meetings with your PHCT?

If Yes, do they use these meetings to communicate, update and liaise with staff regarding child protection issues?

Yes N=28  No N=2  No response N=11
9. Do you have a system within your PHCT that enables you to be aware of children registered at this Practice who are causing concern or who are on the Child Protection Register?

![Pie chart showing responses to question 9]

10. Do you know where the XX Child Protection Procedures are kept?

Yes N=37
No N=4

Any comments you would like to make

- I do not know who PW is but assume it’s one of the HV’s. Both our HV’s attend PHCT weekly meetings and openly discuss concerns and offer support/advice to all PHCT members.
- I am not convinced that knowledge of these procedures or how to identify a child thought to be at risk is present across the practice. A more active role for the key person is required although I appreciate the severe time restrictions they work under.
- If I have concerns I discuss them with my Clinical Supervisor and then with the PCT Child Protection Advisor. On occasion I have contacted the NSPCC Help Desk and Social Services. In every instance I would keep the GP informed of my concerns and actions taken. It would be documented in my notes.
- Since I am only at the practice for 6 hours a week this affects my involvement in this area.
- We are really taking this all on board and the whole thing is being dealt with enthusiasm as it’s so very very important.

THANK YOU. Please return the questionnaire in the envelope provided.
Report for Service Development (anonymised)

Baseline Audit undertaken into the role of the Prime Worker for Child Protection within Primary Care for XX Primary Care Trust.

Executive Summary.
The concept of a Prime worker for Child Protection within primary care is embedded within the Area Child Protection Committee procedures for the county and pivotal within the Child Protection Policy of the PCT where the author is employed. An audit of the role of the Prime worker was undertaken from November 2004 – February 2005. The baseline audit was undertaken to set standards for this role, as since inception in 1997, this role has not been evaluated locally or standards set. The audit provides evidence that at practitioner and Primary Health Care Team (PHCT) level, there appears a general commitment to the role and value of the Prime worker and that this role should be continued and developed. The results have strengthened the questions raised in the Policy analysis (Smith 2004), a new theoretical perspective of ‘chaos’ has been briefly explored and recommendations made to be taken forward.

1. Purpose.
The purpose of this report is to analyse the findings of the audits in relation to how this Service Development Project will benefit the Primary Care Trust (PCT) child protection systems and networks. Theoretical perspectives relating to the findings will be explored and debated and recommendations to be taken forward will be presented.

2. The aim of this project:

- A Baseline Audit describing the role of the Prime worker as it is now, which can be used to set standards for the role of the Prime worker that can be measured.
- To review the current system of prime worker via the quality assurance cycle of monitoring, measuring and evaluating practice against a set of agreed criteria, in order to provide a high quality child protection service to families in ‘XX’ PCT.
To provide data for a larger in-depth study into the role, function and value of the prime worker for child protection from an organisational perspective.

3. Analysis of findings (please also refer to full results submitted).

The response rates of 86% for Prime workers (PW) and 69% for Primary Health Care Team (PHCT) questionnaires was very positive and reinforced the notion that this topic should be explored and that issues relating to support networks for child protection were important and sought across the PCT.

The audit provided evidence that for some Practitioners and PHCT's the role of Prime worker is effective, working well and providing a system of communication and support relating to child protection and welfare issues within primary care. However, for others there is evidence that it is not (see results) and this is of concern as issues relating to poor communication at all levels has been a key recommendation from child death Inquiries spanning 30 years (DH 1995, Laming 2003, Lupton et al 2001, Reder et al 1993). The PCT has a responsibility to ensure systems are in place across the PCT (Smith 2002) and it cannot be in the best interests of children to have a two-tier or fragmented system.

A wide range of PHCT members and length of service was represented in the sample with 74% (n=41) of the sample aware of the existence of a Prime worker with a good overall understanding of the role. However, it is a concern that 25%
(n=14) had not heard of a Prime worker (PW) and identified an urgent need to address this.

Evidence from the Prime worker questionnaire demonstrated that 73% (n=14) of the nominated PW's were senior experienced health visitors qualified for more than 10 years with 52% (n=10) being a PW since the role was established in 1997. It was surprising that although 68% (n=13) had received no training to the role of PW (and those that stated that they did, there was only actually an initial launch rather than formal training), and only 36% (n=7) had a copy of the objectives for PW that 68% (n=13) were clear or very clear about their role. However that left 31% (n=6) unsure or confused about the role. This was concerning as this number represented 25% of the total number of PW's within the PCT. The risks here vastly increase regarding the breakdown of the systems in place since inception in 1997 for those PHCT's where the PW is confused about their role, and the PHCT members unsure who to go to if they have a concern about the welfare of a child. It was not possible for reasons of anonymity and confidentiality to find and match this information to specific teams. However, the future development of the systems in place for child protection in primary care will be disseminated, implemented and reviewed across all PHCT's within the PCT.

The PCT has a nominated PW for each PHCT (100%) therefore has met the requirement as stated in the operational policy, yet 84% (n=16) stated this role was not identified in their job description and 100% (n=19) stated that they did not receive any financial support or specific on-going training in order to undertake this role. These findings could question the organisational commitment, value or understanding of the role of PW. Or is that through constant change, re-organisation and a 'target driven' NHS that the momentum to this role has not been sustained? Initiatives must be supported if they are to continue. Questions arise as to who should drive this initiative. Clearly there needs to be strong leadership and commitment if Prime workers are to become the 'champion' within primary care in respect of child protection. This will be explored further in a more in-depth study where particular interest is drawn towards how organisations...
manage change and the impact of change on structures within the organisation. If the PW were GP’s would the conditions be the same?

68% (n=13) of the PW’s attend regular meetings within the PHCT, but it is a concern that 31% (n=6) did not and of those that did, not all had the opportunity to liaise and disseminate information relevant to child protection. These findings are also reflected in the PHCT questionnaire. A key objective of the role of PW at the outset was to facilitate and co-ordinate communication within the PHCT and this may prove difficult without attending PHCT meetings. This concern was reinforced by the findings from the PHCT members in that only 40% (n=22) had ever liaised with the PW on any aspect regarding the welfare of a child, although there was clear evidence that those members of the PHCT who had heard of the PW knew how to access him/her and 61% (n=34) stated that within the PHCT there was a system that enabled them to be aware of children who were causing concern or who were on the Child Protection Register.

Only 52% (n=10) of the PW’s stated that they felt the role of PW was valued (see comments in results). This reflects the anecdotal evidence that was initially presented by the PW’s. However, the PHCT had a good overall understanding of the role (see comments in results). It was surprising that 42% (n=8) would prefer someone else to undertake the role of PW, however 84% (n=16) stated the role should be continued and 78% (n=15) that the role should be developed. The comments made by the PW’s throughout the questionnaire are very valuable (see results) and centre around training, recognition and support in order to undertake this role.
In your opinion, should this role be continued?

This baseline information will be taken forward and questioned in the larger study to be undertaken. However, overall these findings are not surprising but provide evidence that this role is identified as important and consideration should be given to formalising this role, re-launching it with Policy and Procedures to support it.
4. Theoretical perspectives.

The topic for this Service Development Project was a recommendation of the Policy Analysis undertaken in 2004 that looked at the PCT Child Protection Operational Policy. The concept of Prime worker is firmly embedded in the PCT Policy. Two theoretical perspectives were used as a framework – Gunn (1978) and Benson (1983), and will be explored here further in relation to the findings from the audits. Benson’s (1983) model of Interorganisational Policy Analysis has been applied at the Intraorganisational level, as here there is still the potential for conflict over the key dimensions for equilibrium. The ethos of developing the role of Prime worker was to improve Inter and Intra organisational working. Within an organisation there are many different disciplines, external and internal drivers for the attention of the workforce and resources available to sustain initiatives. It could be argued that with the initiative of the Prime worker role, there is now a widening gap in the domain consensus (who does what) and ideological (how it is done) consensus. Evidence to ‘positive evaluation’ of the role has been identified and provides motivation to continue to explore this topic. There is evidence of ‘alignment of working patterns and cultures’, but at this stage not across all PHCT’s. It is viewed as crucial by the author that the Intraorganisational perspective to the role of Prime worker is obtained if the four key dimensions of equilibrium described by Benson are to be fully implemented, formalised and the initiative re-launched and sustained. It is also recognised that there are also limitations to this ideology, as organisations such as the PCT are ‘highly susceptible to external pressures and are cross-sectoral and multilevel in nature’ (Lupton et al/2001:23).

In relation to Gunn’s (1978) conditions for ‘perfect implementation’, the evidence provided in this project demonstrates that not all the key areas are being addressed which could be the reason this initiative could not sustain the original momentum. Particular regard should be given to exploring in depth and giving further consideration to implementing the key areas 2, 5 and most importantly 6 (see appendix).
Undertaking this Project, a new theoretical perspective emerges – that of Chaos (Wheatley 1999). The theoretical constructs of Chaos originate in biology, mathematics and computer science, but according to Brocklehurst (2004), have become popular within change agents in Primary Care. He proposes that confusion, contradiction and complexity seem appropriate in virtually every sphere of professional activity from policy to practice. He argues this particularly in relation to health visiting, however his concepts can also be applied to child protection systems and networks. The findings of these audits would not describe the system of PW as truly chaotic, yet there is evidence of confusion and disorder and that the system in place being sensitive to changes in conditions. It could be argued that child protection and the systems in place to protect children can never become linear and organised. Behaviour tends to conform to a basic set of implicit rules directed by policy, although ‘events can and do produce unpredictability and novel patterns of organisation and relationships. When combined, they result in an apparent paradox of superficial chaos’ (Brocklehurst 2004:135). Unfortunately, we have not seen the last child death Inquiry or able to provide robust systems to protect all children from abuse or prevent human error. However, Morgan (1997:263) proposes that ‘If a system has a sufficient degree of internal complexity... randomness, diversity and instability become resources for change. New order is a natural outcome’. Therefore, at this stage with the evidence provided from the audits, this would appear an appropriate and interesting theoretical perspective to explore and in more depth in the next stage of the exploratory process in examining the role, value and function of the PW for child protection and trying to understand the direction this role has taken and may take in the future.

5. Recommendations.

5.1 An immediate response to the findings from these audits is to devise a framework protocol to the role of Prime worker and outline Standards (see appendix), which will be taken to the Prime worker group for discussion, debate and to formalise into a final document. Involvement
of the Prime workers in this process ensures inclusion and ownership to the ultimate decisions made.

5.2 Annual audit of the Standards.

5.3 Raise an awareness of the role of Prime worker across the PCT through the child protection newsletter.

5.4 Training Needs Analysis.

5.5 To raise their profile, the Prime workers will be asked to facilitate the Commission for Health Improvement (CHI now CHAI) Audit that will be undertaken across the 24 PHCT's looking at the child protection arrangements within these clinical teams.

5.6 An in depth research project using Q-methodology (phase 1) to gain insight at a strategic level into the 'ownership' of the role Prime worker through ranking existing perceptions of the value of this initiative and how it is perceived staff should be supported in practice in relation to child protection. Exploration (phase 2) of the systems in place within other PCT's to support staff within Primary Care in relation to child protection.

Conclusion.

This project is just the beginning for service development exploring the role and value of practitioners working 'at the coal face' supporting, communicating and facilitating child protection. The ACPC Procedures and Child Protection Operational Policy of the PCT acknowledge the Prime worker as having a pivotal role. The audits provide evidence that at practitioner and PHCT level, there appears a general commitment to the role and value of the Prime worker and that this role should be continued and developed. The findings from the PHCT illuminate that it is the knowledge, support and communication that is most valued and effective. The problems identified relate to clarity, support and training to the role. The results have strengthened the need to answer the questions raised in the Policy Analysis, and have raised new questions which may be answered through exploring organisational perspectives to supporting staff in primary care in relation to safeguarding the welfare of children.
References.


Appendix 1

Letter to Prime Workers (ANONYMISED)

Lorraine Smith
Named Nurse for Child Protection
XX PCT
Tel:

10th December 2004

Dear

RE: Audit of the Role of Prime Worker for Child Protection

As discussed at the Prime workers meetings, I am undertaking an audit of the role of the Prime worker for Child Protection.

Aims:

1. A baseline audit describing the role of the Prime worker as it is now, which will be used to set standards for the role of the Prime worker that can be measured.
2. To review the current system of Prime worker via the quality assurance cycle of monitoring, measuring and evaluating practice against a set of agreed criteria, in order to provide a high quality child protection service to families within XX PCT.
3. To provide data for a larger in-depth study into the role, function and value of the Prime worker for child protection.

Rationale:

The role of Prime worker was introduced into XX PCT in 1997. This was following three Case Reviews that identified an urgent need to provide more effective support to GP surgeries across the County. The Health Visitor was thought to be the most appropriate person to undertake this role. Objectives were identified for this role and disseminated to a nominated Health Visitor in each GP Practice.

Since 1997, the role of Prime worker has never been formalised, evaluated or audited. The XX Child Protection Procedures state that 'Each GP Practice will have a named Prime worker for child protection'. The XX procedures are based on the policy document 'Working Together' (DH 1999). The PCT has a nominated Prime worker at each GP Practice, therefore has reached 100% requirement as stated within the document. The PCT has a Child Protection Operational policy that incorporates the role of Prime worker, however has no Standards by which to measure this role.
I enclose a questionnaire that should take you no more than five minutes to complete. It is important that you all please respond as you are undertaking this role and the data collected will be extremely valuable. The questionnaire is anonymous and the Clinical Audit Support Unit will collate the data.

Questionnaires will also be sent to a random sample of other Primary Health Care staff to gain a perspective of the perceived role of the Prime worker. The replies will be anonymous and it will not be possible to identify individual Practices. The full results of this Audit will be available to you, hopefully by end of February 2005.

THANK YOU for completing this questionnaire. Please return it in the envelope provided by 22nd December. Do not hesitate to contact me if you wish to discuss anything.

Lorraine Smith.
Letter to Primary Health Care Team (ANONYMISED)

Lorraine Smith
Named Nurse for Child Protection
XX PCT
Tel:

10th December 2004

Dear Colleague,

RE: Audit of the Role of Prime Worker for Child Protection.

I am undertaking an audit of the role of the Prime worker for Child Protection. Part of this audit is to gain the perspective of the perceived role of the Prime worker from members of the Primary Health Care Team (PHCT). Various members of the PHCT have been sent this questionnaire, which is completely anonymous and when the questionnaire is returned in the envelope provided, it will not be possible to identify individual Practices. Each Practice Manager has been sent 3-4 questionnaires and asked to randomly select a member of staff to give the envelope (i.e. 'please give to 1 GP, 1 Practice Nurse, 1 Clerical member of staff').

Aims of this Audit:

1. A baseline audit describing the role of the Prime worker as it is now, which will be used to set standards for the role of the Prime worker that can be measured.
2. To review the current system of Prime worker via the quality assurance cycle of monitoring, measuring and evaluating practice against a set of agreed criteria, in order to provide a high quality child protection service to families within XX PCT.
3. To provide data for a larger in-depth study into the role, function and value of the Prime worker for child protection.

Rationale:

The role of Prime worker was introduced into XX PCT in 1997. This was following three Case Reviews that identified an urgent need to provide more effective support to GP surgeries across the county. The Health Visitor was thought to be
the most appropriate person to undertake this role. Objectives were identified for this role and disseminated to a nominated Health Visitor in each GP Practice. Since 1997, the role of Prime worker has never been formalised, evaluated or audited.

The questionnaire should take no more than 5 minutes to complete and I reinforce that your response will remain anonymous. Your perspective is extremely valuable.

THANK YOU. Please return the questionnaire in the envelope provided by 22nd December. Please do not hesitate to contact me if you wish to discuss anything – Tel: ....

Lorraine Smith.
Appendix III

Framework Protocol and Outline Standards to the role of Prime worker (anonymised).

Prime worker for Child Protection within Primary Health Care Teams.

This protocol has been formulated using the Prime worker Objectives set in 1997 and from the results of the Baseline Audits undertaken in November 2004 – February 2005.

Aims

- Each GP Practice / Primary Health Care Team will have a key professional identified who will develop and maintain effective communication systems within the Primary Health Team (PHCT) relating to Child Protection.
- A support mechanism for Child Protection within PHCT’s will be provided.

(Section 8.4 of XX Child Protection Procedures).

Guiding Principles as embodied in the XX Child Protection Procedures and PCT Child Protection Operational Policy.

1. The welfare of the child is paramount, and children are entitled to protection from abuse, neglect and exploitation.
2. Members of the Primary Health Care team will adhere to the XX Child Protection procedures.
3. Members of the Primary Health Care Team will work together constructively to protect children.
4. Members of the Primary Health Care team will disclose information on a need to know basis when they suspect that a child is 'in need', as well as where they suspect that a child is at risk of significant harm i.e. in need of protection.
5. Primary Health care team members will work in open and honest partnerships with parents and carers to achieve a maximum level of partnership and therefore a better outcome for the child.
6. There will be exceptions when it may be necessary to disclose information to Social services / Police prior to discussing concerns with the family i.e. Fabricated Illness, or where your personal safety is perceived to be at risk.

Responsibility for implementing and updating this Protocol is with the Named Nurse for Child Protection for XX PCT.
Protocol.

- **Scope**
  
  Every Primary Health Care Team (PHCT) within XX PCT will have a named Prime worker and every member of the team must be aware who the Prime worker is.

- **Nomination.**
  
  The Prime worker for Child Protection will be nominated from within the existing Health Visiting Team at the GP Practice, Medical or Health Centre. The child protection Nurse Advisors for XX PCT will undertake this selection in negotiation with the Practice staff.

- **Child Protection advice to Primary Health Care Team.**
  
  The Prime worker will be required to give advice and support to any member of the PHCT who has concerns about a child.

  It is appropriate for the Prime worker to advise and mentor team colleagues but not to supervise. If at any time the Prime worker is unsure or the concerns appear complex, advice must be sought from a member of the PCT Child Protection Team.

  It is acknowledged through the Chief Nurses Report (2004) and the National Service Framework for Children, Young People and Maternity Services (2004), that practice nurses may need a more formalised system of mentoring. Prime workers may undertake this formalised mentoring following specific training to this role (refer to Supervision Protocol). This training will be provided and the mentoring process monitored and supported by the PCT Child Protection Team.

- **Communication within the PHCT in relation to Child Protection.**
  
  - The Prime worker will co-ordinate the information flow within the Practice and encourage discussion within the Practice about Child Protection issues to promote sound planning.
  - Prime workers are encouraged to attend regular Primary Health Care Team meetings.
  - The Prime worker in respect of child protection issues will promote liaison between the PHCT and other Agencies such as Social and Caring Service and Education.
  - The Prime worker will facilitate the PHCT to follow the XX Procedures in relation to preparation and attendance at child protection conferences.
  - The Prime worker will work to ensure that there is good preparation for, and that good quality reports are presented at Child Protection Conferences.
• The Prime Worker will inform GP’s and other members of the PHCT (as appropriate) of the outcome of the Child Protection Conference.

—in the role of the School Nurse.

Prime workers and school nurses need to develop an effective working relationship in order to share information and communicate issues and concerns relating to promoting the welfare of children within the Practice.

School Nurse Representatives will be invited to the Prime worker meetings.

—in order to undertake this role.

Management issues of Prime workers rest with the Nurse Advisors, who will support, advise and supervise the Prime workers. They will also update other agencies with any changes made to the role of Prime Worker.

The Child Protection Team for the PCT will provide training specific to the role of Prime worker for Practitioners new to this role. A training needs analysis will be undertaken and reviewed annually.

Prime worker meetings will be held bi-monthly, facilitated by the Child Protection Team. These meetings will provide the forum to discuss and disseminate information relating to Child Protection Issues. The Prime workers meetings will also be the forum to advise and discuss issues relating to Child Protection Policy, Protocols and Procedures.

—in the PHCT.

When a new member of staff joins the Primary Health Care Team (even temporarily), the Prime worker will ensure that they are made aware where the Child Protection Procedures and ‘What To Do If...’ flowcharts are located. This could be facilitated given written information / leaflet.

—in Monitoring.

An annual Audit will be undertaken relating to the role of The Prime worker using the criteria identified overleaf.

<table>
<thead>
<tr>
<th>Criteria.</th>
<th>Standard.</th>
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<tbody>
<tr>
<td>1. Each GP Practice / Primary Health Care Team (PHCT) will have a named Prime worker for Child Protection.</td>
<td>100%</td>
</tr>
<tr>
<td>2. Each member of the PHCT will be able to identify who the Prime worker for Child protection is.</td>
<td>100%</td>
</tr>
<tr>
<td>3. Every member of the PHCT will be able to identify where the 'What To Do If...' flow chart is located.</td>
<td>100%</td>
</tr>
<tr>
<td>4. All Prime workers within the PHCT will receive training to the role and attend specific updates provided by the PCT Child Protection Team.</td>
<td>100%</td>
</tr>
<tr>
<td>5. The Prime worker (or in absence, a health visitor colleague) will attend regular Practice meetings to disseminate information and update the PHCT regarding child protection.</td>
<td>80%</td>
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<tr>
<td>6. When a new member of staff joins the Primary Health care Team (even temporarily), they will be given guidance on child protection within one week.</td>
<td>100%</td>
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<tr>
<td>7. All Prime workers will attend 50% of the Prime worker Meetings.</td>
<td>100%</td>
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</table>
Appendix IV

Benson's Model of Interorganisational Policy Analysis


'The four key dimensions of equilibrium'

1. Domain consensus -
   - Agreement regarding the appropriate role and scope of each agency.

2. Ideological consensus –
   - Agreement regarding the nature of the tasks faced and the most appropriate way of approaching them.

3. Positive evaluation –
   - By workers, in one organisation of the work of others.

4. Work coordination –
   - Alignment of working patterns and cultures.
Appendix V

Gunn's conditions for 'perfect implementation' adapted for 'evidence-based medicine'.


1. Sufficient material resources in the appropriate combination available – beyond money, skills or shortages.

2. Sufficient non-material resources – 'real-world organisations have ongoing activities and other priorities with which new policies have to compete for attention.

3. That the policy to be implemented is based upon a valid theory of cause and effect.

4. The relationship between cause and effect is direct and that there are few, if any, intervening links – 'reminds us that most organisational endeavours require the cooperation of teams of individuals, and that the more links in the chain, the more likely it is that at least one will break down.

5. The external dependency relations are minimal – 'refers to political factors such as the refusal of other organisations to cooperate in implementing the policy.

6. That there is understanding of, and agreement on objectives of the policy and how they are implemented throughout the organisation: that is, that there should be no conflicts within the implementing organisation and that everyone should clearly understand what they have to do and when. This condition reminds us that organisations are frequently characterised by resistance, conflict disagreement and misunderstanding.