

Delivering safeguarding children services in primary care: responding to national child protection policy

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Aim: This study set out to examine how Primary Care Organisations (PCOs) in England manage, organise and deliver their safeguarding children responsibilities.

Background: In the light of changing organisational configurations across primary care, a wealth of policy directives and a climate of extensive media attention around child protection, this paper focuses on how PCOs respond to national policy and deliver safeguarding children services. **Method:** This study, based in England, United Kingdom (UK), used a telephone survey method incorporating semi-structured qualitative interviews with Designated Child Protection Nurses. A maximum variation sampling strategy was used to identify two to three PCOs within each of the original 28 Strategic Health Authority sites. From the 64 PCOs approached, 60 Designated Nurses or their representatives agreed to participate in the research, with a response rate of 94%. Data analysis was informed primarily by Lincoln and Guba's (1985) three stages of a) unitising, b) categorising and c) pattern search. **Findings:** The findings outline how and to what extent PCOs respond to the national policy and organise and deliver their child protection services. The paper highlights some of the key challenges facing PCOs, in particular, safeguarding moving off the primary care agenda, child protection staff recruitment difficulties, a proliferation and overload of policy, resource implications for additional staff training, challenges to collaborative working, high referral thresholds to social care services and cutbacks in public health nursing services. This paper concludes by offering some suggestions about how child protection services could be improved as primary care faces another major reorganisation with the demise of Primary Care Trusts in April 2013.

Key words: child protection policy; designated professionals; national survey; primary care; safeguarding children

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Introduction

In the United Kingdom (UK), since April 2002, in line with power devolution as outlined in *Shifting the Balance of Power* (Department of Health, 2001), the responsibility for providing the

health contribution to Child Protection Services was transferred from Strategic Health Authorities (SHAs) to local providers of health care and Primary Care Trusts (PCTs). This study sought to examine how Primary Care Organisations (PCOs), including PCTs, Care Trusts and Children's Trusts, organise and deliver their safeguarding children responsibilities.

The public inquiry in England, into the death of Victoria Climbié, drew significant national and international attention to the failings of public

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agencies to protect a vulnerable child (Lord Laming, 2003). Laming's damning report highlighted significant problems in both single- and multi-agency work and cited 'widespread organisational malaise' (Lord Laming, 2003: para 1.21) as the main reason for failing to protect Victoria.

The Climbié case mirrored events in other western countries where similar high-profile cases are followed by increasing regulation, inspection and updated child protection legislation (Durfee *et al.*, 2002; Kanani *et al.*, 2002; Lachman and Bernard 2006). In England, Laming's inquiry resulted in a series of good practice recommendations and was closely followed by the government's response *Keeping Children Safe* (Department for Education and Skills, Department of Health and Home Office, 2003) and the Green Paper *Every Child Matters* (Department for Education and Skills, 2003).

In 2003, the Commission for Health Improvement (CHI) audited the implementation of these 108 practice recommendations through a self-assessment audit of National Health Services (NHS) organisations' child protection arrangements. Although this national audit found some evidence of good working practices, considerable concerns remained around key issues highlighted in the *Climbié Inquiry* (Lord Laming, 2003), particularly around how professionals and organisations work together, communicate and share information (Commission for Health Improvement, 2003).

In the United Kingdom, subsequent policy and legislation, including The Children Act (2004), *Every Child Matters: Change for Children* (Department for Education and Skills, 2004) agenda and revised *Working Together* (HM Government, 2010) guidance, have been directed at remedying these deficits through an increasing focus on cross-organisational working. It seemed timely therefore to examine how service configurations across primary care are working to safeguard children amidst a changing policy agenda. It is the first research study that has attempted to develop a knowledge base about safeguarding children service delivery across PCOs. This paper describes Designated Professionals' perspectives on child protection work in primary care. It follows Laming's (2009) recent review of safeguarding children practices in response to baby Peter Connelly's death in Haringey, London (Haringey Local Safeguarding Children Board, 2009).

Laming's (2009) progress report was significant in highlighting a climate of excessive bureaucracy, the under-resourcing of front-line children's safeguarding services and the need for improvements in leadership, training and support for staff working with children and families (Appleton and Stanley, 2009). In addition, the Care Quality Commission's (2009) survey of NHS trust arrangements for safeguarding children reinforced these issues, reporting that NHS trusts could do more in relation to safeguarding children, a point also highlighted in the Kennedy report (2010).

The change of English Government in 2010, combined with other high-profile child deaths including Khyra Ishaq (Radford, 2010), prompted Professor Eileen Munro to be appointed to conduct an independent review of child protection. Munro's initial report (2010; 2011: 9) described how professionals are 'constrained from keeping a focus on the child' by the rigidity and demands of inspection, regulation and managerial targets.

Methods

This national study used a telephone survey method incorporating semi-structured qualitative interviews with Designated Nurses across England. It addressed the following research question: How do Designated Child Protection Nurses in England perceive that the new PCOs are managing, organising and delivering services to meet their child protection responsibilities in the context of increased interdisciplinary and multi-agency working?

The telephone survey was selected as an appropriate method to facilitate the recruitment of respondents across a wide geographical area, where speed was important in a time of rapid policy development (Oppenheim, 1992; Lavrakas, 1993) and when the intention was to build up a detailed picture of child protection working practices. For these reasons, including its ability to improve response rates (While and Dyson, 2002; Sturges and Hanrahan, 2004) and evidence that data quality is not unduly affected (Sturges and Hanrahan, 2004), the telephone survey is increasing in popularity as a legitimate data collection method in primary care research (Dowswell *et al.*, 2002; Cameron and Statham, 2006).

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Musselwhite *et al.* (2007) highlight the need for clarity around telephone interview procedures to prepare potential respondents in advance for this method. A reminder may be needed about setting up a private space to protect confidentiality and avoid distractions, scheduling the interview at a quiet time, use of a landline and checking out whether it is convenient to go ahead (Smith, 2005). Although it is impossible to observe the interviewee's non-verbal communication during the telephone interview, Musselwhite *et al.* (2007: 1066) have suggested that rather than being a disadvantage, this may result in a more relaxed interview as both parties 'are potentially less affected by each other's presence'. Building rapport with respondents, careful wording of questions and the avoidance of interviewer bias are important aspects of the telephone interview technique (Smith, 2005).

Sample

The Designated Nurse for Child Protection in each PCO was identified as the key informant. Designated Nurses are senior professionals who 'take a strategic, professional lead on all aspects of the health service contribution to safeguarding children' (HM Government, 2010: 67). Their views on the progress of implementation of change were important in determining how PCOs were responding to national policy and delivering multi-agency safeguarding children services.

A maximum variation sampling strategy was used to identify two to three PCOs within each of the original 28 SHA sites, three Care Trusts and four pilot areas. Maximum variation sampling is aimed 'at capturing and describing the central themes' (Patton, 1990: 172) and unique variations that can emerge in an inquiry. It was selected to reflect geographical variation, levels of deprivation and different organisational configuration. A total of 64 PCOs were included in the study.

Ethics and research governance

Ethical review was obtained from the National Research Ethics Committee. Permission to access each PCO and approach the Designated Nurse was sought from each trust's chief executive. Once research governance approval had been obtained, Designated Professionals were recruited to participate in the study, with informed consent being sought from each.

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Data collection

From the 64 PCOs approached, 60 Designated Nurses (or their representative) agreed to participate, with a response rate of 94%. The main study interviews took place between December 2005 and May 2006. Telephone interviews were conducted at a convenient time for the participants, from a venue and landline of their choice. A semi-structured interview schedule was designed to gather information about how PCOs were responding to national policy and organising local child protection services. The schedule was developed using themes that had emerged from an initial review of policy guidance, serious case review evidence, previous child abuse death inquiry reports and research recommendations. Interviews were audio-recorded and lasted for 1–2 hours.

Data analysis

Following each telephone interview, data were fully transcribed and numerically coded to ensure the anonymity of respondents and PCOs. Reading the transcripts several times allowed for initial immersion in the data. Interviews were then imported into QSR**N6* software to assist with data handling and retrieval. Data analysis was informed primarily by Lincoln and Guba's (1985) three stages of unitising, categorising and pattern search. Interviews were initially coded by means of an inductive and data-driven approach. Codes were constantly compared, questioned and refined, so that where similarities and relationships were identified, codes were either merged together or developed into a hierarchy with a main category and subcategories. As the analysis progressed, codes and categories were continually challenged, checked with the original transcripts, reworked and disconfirming evidence was sought. Pattern search involved establishing commonalities, differences and inter-relationships across the data set. Emergent findings were discussed with the project steering group to consolidate ideas.

Findings

Respondents

Of the 60 PCOs, 56 were represented by Designated Child Protection Nurses, one of

whom was an Acting Designated Nurse. Other representatives included:

- Director of Nursing/Named Nurse* Child Protection
- Director/Manager Safeguarding Children
- Child Protection Advisor/Named Nurse*
- Named Nurse* Child Protection.

Three participants spoke on behalf of two separate PCOs; thus, 53 Designated Nurses participated in the study. Sixteen (30%) of the 53 Designated Nurses were also Nurse Consultants. In total, 57 separate respondents represented the 60 participating PCOs. Respondents were asked to focus in particular on the trust they were representing, although all Designated Professionals did talk broadly about safeguarding issues across all provider trusts they had responsibility for. Out of the 57 respondents, 54 (95%) were women and 3 (5%) were men.

Organisation of safeguarding children services

There is considerable variation and complexity in the way safeguarding children health services are organised in primary care. Some Designated Professionals had child protection responsibilities across one PCT area, including all provider organisations, whereas others had responsibility for a district with up to six neighbouring PCOs, including acute hospital and mental health trusts. The National Safeguarding Children Association of Nurses found a similar picture in an email survey conducted in late 2006 (Lambert and Clibbens, 2006). This complexity appears to be a direct result of the different management structures in place, differences in the way health services are organised in primary care, with a variety of child protection team structures and members, and varied contractual arrangements for key personnel, such as Designated and Named Professionals.

Profile of child protection work

In primary care, ensuring the health and well-being of children is a key public health task.

*The focus of the named nurse role is the practical operational aspects of safeguarding children within a single organisation (eg, primary care or hospital trust).

The Children Act (2004) states that all health care organisations have a duty to make arrangements to safeguard and promote the welfare of children and young people. Designated Professionals drew attention to not only the child protection aspects of safeguarding but also the broader children's well-being agenda and the recognition that PCTs had to become more children and young people friendly.

Our first point was creating and fostering a child and young person centred culture in the PCT...

(DN 10)

The focus on safeguarding reflects a much wider spectrum of activity and delivery, as well as protection, and encompasses prevention and an emphasis on safety for all children, not just those in need, or suffering, or at a risk of suffering significant harm. The majority of respondents were highly supportive of the recent policy shift, with its focus on early intervention; yet, several stressed the need to ensure that vital resources are not diverted away from acute child protection work.

Most respondents were clear that the CHI audit (2003) and Laming Report (2003) had raised the profile of child protection work in primary care. One stated:

I think it's far more visible on the agenda, I think people who historically wouldn't necessarily have thought child started to think child ...

(DN 7)

Those PCOs recognising their safeguarding responsibilities had provided additional named nurse time, increased opportunities for child protection supervision, made services more children and young people friendly, established child protection health advisory groups and widened training opportunities in recognition that all staff in the organisation have safeguarding responsibilities. Furthermore, over half of the Designated Professionals, 38 (63%), described having direct access to Trust Chief Executives to discuss important child protection issues, which reflected the importance of their voice within the organisation.

In contrast, Care Trusts with Mental Health Service responsibilities were still working hard to get fundamentals in place, such as implementing

basic safeguarding awareness training and engaging adult mental health workers in recognising and considering children's needs. One respondent commented:

... for us the priorities have been about thinking about children, being child centric, not just seeing the adult in front of you in isolation ...

(DN 12)

Indeed, the failure by adult health workers to take account of the needs of the child is a feature in some cases that have reached the threshold for Serious Case Reviews (Brandon *et al.*, 2009).

Clinical governance

Respondents talked favourably about organisations being required to have clinical governance arrangements to ensure the quality of child protection services. As commissioners of services PCTs are 'expected to ensure that arrangements are in place to promote and safeguard the health and well-being of children and young people, and that health services and professionals contribute to inter-agency working' (Department of Health, 2002: 2). Most organisations had a strategic plan for safeguarding, and child protection monitoring was on going in all. Many respondents described how since the Laming Report (2003) trust board

members had increasingly recognised their safeguarding responsibilities. One said:

I think we've still got a long way to go but I think that the benefit from it was that it forced the Board to think about child protection as a priority issue which they haven't had to do really in the past. ... It's something that other people have managed for them and they haven't really got worried about it unless anything serious has gone wrong

(DN 13)

Seventy-two percent ($n = 43$) believed that trust board members had a 'good' or an 'excellent' awareness of their organisation's child protection responsibilities.

Collaborative working

Participants were extremely committed to collaborative working at strategic and operational levels, believing that effective multi-agency working increases the likelihood of improved outcomes for children. The data revealed some excellent examples of collaborative practice (Figure 1). Yet, there was little evidence of formal evaluation of many local projects.

There was also evidence that some General Practitioners (GPs), traditionally shown in research as difficult to engage in child protection processes,

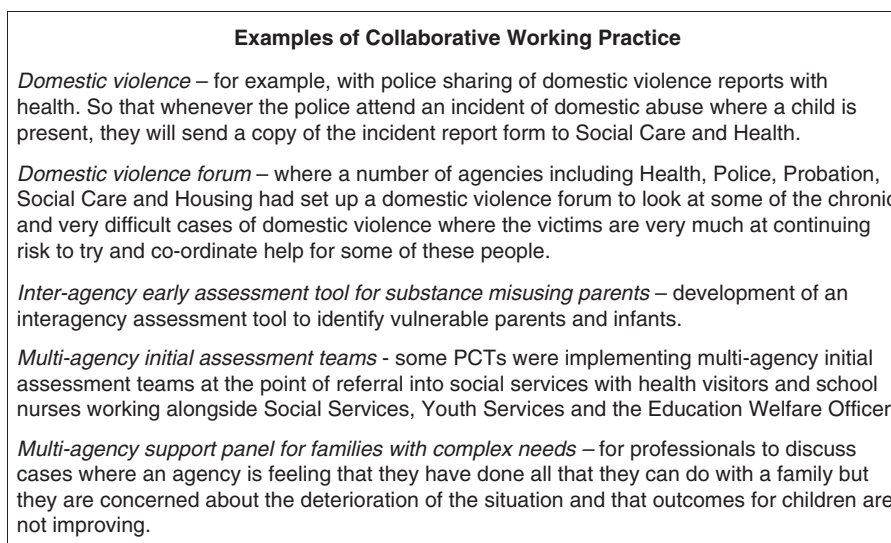


Figure 1 Collaborative working practices

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were acknowledging their safeguarding responsibilities. Previous research has highlighted GPs' minimal involvement in the initial identification and referral of child abuse cases to social services, their poor attendance at child protection conferences, lack of clarity about roles, issues around confidentiality and concerns about the impact that their involvement in a child protection case may have on their ongoing relationship with families (Birchall and Hallett, 1995; Lupton *et al.*, 2001; Sinclair and Bullock, 2002). However, in this study, over one third of the respondents talked about GPs increasingly requesting practice child protection training events, seeking advice from designated/named professionals and implementing safeguarding children GP practice protocols.

Challenges in delivering safeguarding services

Despite respondents' positive reports about how PCOs are addressing safeguarding responsibilities, there are clearly many challenges facing organisations.

The policy deluge

Designated Professionals reported that trusts were continually expected to respond to safeguarding policy directives and very often they took the lead, working in conjunction with named professionals on ensuring that local child protection arrangements met national safety standards. Several participants raised concerns about the large number of policy directives (national and local) impacting on primary care. One stated: '*there's an absolute deluge of it*' (DN 54), another commented '*I'm just fed up with it... I could spend all my time reading documents and not doing the work*' (DN 28).

Concerns were also raised that '*the plethora of documents*' (DN 10) often contained duplicate material, with much of the policy directed at social care and in some cases failing to acknowledge the universal service contribution of health agencies. This latter point is significant in the light of Ofsted's (2008: 5) evaluation of serious case reviews that 'underlined the key role that universal services play in ensuring that children are kept safe'.

Safeguarding moving off the agenda

Several participants raised concerns that safeguarding children may not remain high on PCO agendas with other competing demands for resources. As this Designated Nurse reported, safeguarding children is

very much on the agenda in terms of governance and risk ... but I think it's just about to die a death again

(DN 5)

The PCT reconfiguration as a response to *Commissioning a Patient-Led NHS* (Department of Health, 2005), which reduced the number of PCTs in England from 303 to 152 in October 2006, was announced just before data collection of the study commenced. At the time of the study, respondents did not know how their organisations would be affected, but it was causing considerable conjecture. Participants commented on the stresses associated with the reorganisation and the difficulties in continuing effective coordination across agencies as reorganisations were taking place in other agencies too.

And of course the danger is that when all that's going on, people take their eye off the ball

(DN 7)

Such major service reorganisation has the potential to detract from child-centred practice.

Recruitment and training

The study revealed considerable difficulties in recruiting doctors to named and designated child protection posts. Four organisations had no designated doctor in post and, when commenting on their wider cross trust responsibilities, respondents reported that 17 trusts had no named doctor. Concerns were raised that the post was often in name only, with no time attached to the role.

The difficulty that we do have and we have had is around named GP's, in recruiting them... People don't want to do it. People don't want to get involved in child protection because of the current media interest I think and high profile cases and I think unless you've really, really got your heart in it, then I think that people just steer clear of it

(DN 8)

Contributory factors to recruitment difficulties appeared to stem from the additional workload with a fairly limited remuneration, the huge concern about the potential for litigation and people being very scared about doing what was regarded as 'expert' work.

All staff working with children must be trained and knowledgeable about the signs of child maltreatment (National Collaborating Centre for Women's Children's Health, 2009; HM Government, 2010). Yet, the need to provide additional staff training was placing a considerable burden on some primary care safeguarding teams to secure robustly funded training programmes for their organisations. One participant commented:

We have a very small team and the requirements now for people to be trained are much broader and wider and it's quite a big organisation so really the demand for training outstrips our ability to provide it

(DN 43)

Small teams may lack the capacity required to provide a rolling programme of training and to be responsive to new training requirements. If front-line staff are not fully trained, there is likely to be a failure to identify and report signs of abuse (Ofsted, 2008; Laming, 2009).

High referral thresholds

High referral thresholds to social care, limited resources for work with children in need and high levels of unmet need were key challenges. Respondents reported that social care services were often under-resourced, have considerable staff recruitment difficulties, high staff turnover and/or were going through their own service reorganisation. This represented a common view:

From the practice point of view the thresholds would be seen by most practitioners as quite a problem in terms of referring for either child in need or child protection, that Social Care are under huge stress, are extremely short staffed and take a long time to respond to anything but the most acute problems

(DN 27)

High referral thresholds into social care continue to be a significant problem corroborated by other findings (Department of Health, 2002; Commission

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for Social Care Inspection, 2005; Brandon *et al.*, 2008a; 2008b). One Designated Nurse described the worrying way in which some health staff in her organisation dealt with threshold difficulties:

The high thresholds for referring in to social care is an issue because it makes us concerned that professionals, well they do two things, they'll either manage cases that are very, very high level because they know there is no point in referring them, so they don't bother referring, or, they frequently refer in and then they'll just write a covering letter saying 'I'm no longer involved', because they feel they've done their, you know that's their role fulfilled and I think that is a real concern

(DN 23)

In this case, the Designated Nurse was hopeful that because the problem had been acknowledged by social care, a new multi-agency support panel would go some way towards addressing this problem.

Under-resourcing also meant that in some organisations joint training had not taken place, which impacted on the ability of staff to get to know each other and work together across agencies. Perhaps, surprisingly, lack of knowledge and understanding of other professionals' roles was still a commonly cited barrier to effective joint working.

A small number of respondents also commented on the additional problem of some health staff's inability to express themselves well in referrals to social care. There was a feeling that health staff may not '*do themselves any favours in early intervention and prevention*' (DN 13), because of failures to articulate their concerns and referrals being made too readily with a lack of clarity of what staff expect from Social Care Services.

Public health nursing cutbacks

Another overwhelming concern from participants was of the limited resources in primary care nursing services and the impact on children. Many PCOs were facing considerable budget shortfalls; some areas were on special measures and '*millions over spent*' (DN 11). As a result, several organisations were making major cutbacks in their front-line staffing levels (health visitors and school nurses), recruitment in some

areas was on hold and this was having a significant impact on the morale and practice of the public health nursing workforce, who are key deliverers of safeguarding children services.

This respondent highlighted major shortfalls in school nursing resources:

Staffing is a big issue particularly with school nursing. We have four School Nurses for the whole of the Trust in PCT. The other areas are not quite so bad ... but [Town] is appalling and can't retain staff either because levels are so low when they've had somebody who came, they went again very quickly because they couldn't take the pressure. And another person who came, filled the post, really is crumbling under the weight of the child protection work that she has to do

(DN 11)

Participants also commented on the Chief Nursing Officer's report (Department of Health, 2004), which had recommended a significant increase in school nurse numbers for school populations but that had not happened in practice. Participants talked about low staff morale and people being '*very, very demoralised*' (DN 2) because of the cutbacks:

I think we're culling our Health Visiting service and that flies in the face of [policy] ... and we're introducing skill-mix into Health Visiting like it's going out of fashion ... I know there are a lot more providers out there around Children's Services but I do firmly and really believe that you know we are a universal service, we do have very powerful first contact with children and families and you know, I think we've got to be very careful that we don't just allow that to disappear or be very diluted

(DN 2)

Although recent policy reiterates the need to prioritise preventive work with children and families, many staff raised questions about the extent to which this was really feasible in view of the service cuts in primary health care and other agencies. In many areas of the country, health visitors had only very limited home contact with children and families. Respondents were clearly

worried that with such cutbacks in universal health services, vulnerable children will continue to slip through the net.

Discussion

This study has examined, through telephone interviews with Designated Professionals, how PCO child protection services were being organised and delivered in England, UK, following a period of significant policy development. Although the health contribution to safeguarding children is recognised in primary care, this study revealed considerable local variation in the way services are organised, managed and delivered. Complexity in service delivery results from different management structures, variation in the way primary care services are organised, different child protection team structures, membership and line management responsibilities, and varied contractual arrangements for Designated and Named Professionals.

The Children Act (2004) places a statutory duty on key agencies to cooperate to safeguard and promote the well-being of children. Respondents were committed to collaborative working and the opportunities this provides to improve outcomes for children. They described examples of collaborative working practices, and yet, few of these projects had been properly evaluated. It is therefore difficult to distinguish which interventions are effective, and impact positively on children and families. Some PCTs were implementing multi-agency initial assessment teams at the point of referral into social services. Anecdotally, such initiatives appeared positive, but little is known about the workings and effectiveness of such partnerships. As good practice models are rarely shared countrywide, Government should publicise promising examples online to share good practice, avoid duplication of effort and provide a basis for interventions to be robustly tested.

Conversely, this study also revealed difficulties with collaborative endeavours. Respondents talked about the practical difficulties of promoting collaborative working when organisations have limited resources, do not have shared budgets or compatible IT systems, and the need to really get to grips with the fundamental issue of addressing different organisational cultures. The recent policy driver

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towards an integrated children's workforce has made professional boundaries less distinct, and yet, a lack of knowledge of other professional's roles was a commonly cited barrier to effective joint working.

Organisational challenges to the delivery of safeguarding children services in primary care mirror some of the deficiencies found in previous research evidence (Hallett, 1995; Glisson and Hemmelgram, 1998; Glisson *et al.*, 2006) and serious case review reports (eg, O'Brien *et al.*, 2003; Cantrill, 2005; Rose and Barnes 2008, Care Quality Commission, 2009; Radford, 2010) including fragmented services, limited resources, staff recruitment difficulties, low staff morale and communication problems both within and across agencies. High referral thresholds into social care services were a significant problem. Indeed, the preoccupation with thresholds was a key theme of the third biennial serious case review study (Brandon *et al.*, 2008a; 2008b) and has been picked up by the Munro Review (2011) as part of a need to examine the threshold debate.

There was also a view that safeguarding children was no longer regarded as an organisational priority in primary care as other demands competed for hard-pressed resources. Although UK policy has prioritised strategies to raise awareness of the safeguarding responsibilities of individuals and organisations, in reality, it appears that safeguarding children work is moving off the primary care agenda. This was starkly evidenced in some areas by cutbacks in key front-line staff with preventative roles with children, shortages of skilled child protection experts and deficits in training.

If public health nursing services are adequately resourced these professionals are in an ideal position through The Healthy Child Programme (2009) to identify children who, with their families require advice, support and guidance, including those children who are potentially vulnerable to significant harm. The need to substantially increase the numbers of front-line health visitors has been accepted by the UK government (Department of Health, 2011); however, it remains to be seen how this will be implemented and whether expansion of school nursing services will follow.

Increasing requirements on PCOs for accountability and transparency of child protection services are placing considerable demands on safeguarding specialists to engage in policy interpretation and

audit, as Munro (2005a) also described. Respondents generally felt swamped by top-down policies. Areas were interpreting national policy locally, an apparently time-consuming process, leading to much duplication of effort. The study also raises questions about the extent to which audit and monitoring are being used as indicators of the quality of child protection practice and services. This may be to the detriment of service delivery, as it can mask the needs of front-line staff and their workloads. What is really needed is a primary care workforce who are properly trained, valued and supported in assessing and analysing risks accurately, and skilled in communicating effectively with children, families and other professionals (Munro, 2005b; Balen and Masson, 2008; Ofsted, 2008; 2009).

Study limitations

Although the study provides a unique view of child protection services, it reflects a single snapshot in time and despite the excellent survey response, does represent one interpretation of Designated Nurses' constructions of safeguarding children work. The findings are exclusive to the particular study contexts and as such there is no intention to seek generalisations. However, the respondents were a group of experts working at the leading edge of safeguarding practice. The study therefore affords a useful picture of service delivery across primary care and highlights several challenges that have implications for organisations, policy makers and practitioners.

Where next?

The new government's NHS reforms should be seized as an opportunity to release organisations from the bureaucracy of policy proliferation and overload (Department of Health, 2010). Realistically, as primary care faces yet another massive reorganisation with the demise of PCTs from April 2013, the delivery of safeguarding children faces another major shake-up – this is despite consistent evidence from child abuse inquiries of the dangers to children when organisations go through change. In some regions it is likely that primary care public health services will move into local authority provision. If public health

professionals are co-located into multidisciplinary teams with social care and education staff this could do much to improve the working between front-line professionals in supporting vulnerable children. It could also help to create practical solutions to the problems faced around referral thresholds.

This study has revealed that there needs to be a greater understanding of the skills and competencies of the health care workforce to avoid duplication of effort across integrated children's services, and this could be achieved through such an arrangement. However, as local authority budgets are not protected, it is essential to ensure that health staff with specialist child protection roles do not see their roles diluted and high-quality supervision and training are maintained.

Questions are also being raised about where Designated Professionals should sit – either with the new local authority 'health and well-being boards' or with the new GP commissioning consortia. Being in the former would involve 'joining up the commissioning of local NHS services, social care and health improvement' (Department of Health, 2010: para 4.17), but it is in the latter with a commissioning role that Designated Professionals would be able to exert most influence, advising on commissioning of safeguarding services, promoting preventative family support services and holding providers and GPs to account (A. Roberts, personal communications). As senior professionals, with a wealth of safeguarding experience, they must maintain a strategic role in driving forward child protection services across primary care. This study also indicates that safeguarding leads must be freed up from excessive paperwork to concentrate on providing child protection leadership to health care staff and to ensure that services are fit for purpose.

Conclusion

This study sought to build up a picture of the exercise of safeguarding children responsibilities by PCOs as perceived by Designated Professionals following a period of rapid policy development. This paper has outlined some of the challenges facing primary care, which will be relevant as new organisations replace PCTs in April 2013. Key challenges include keeping safeguarding

children work high on the primary care agenda, removing the proliferation and overload of policy and properly resourcing front-line early identification and preventative services. In addition, there is a real need to gain full acknowledgement for the training and skills required of both specialist safeguarding professionals and front-line staff working with children, young people and their families. It has long been recognised that primary health care professionals play an important role in both identifying vulnerable children and supporting parents, through to recognising children in need of protection. But services have to be resourced properly and continuity of contact provided to children and families as part of universal provision, which is crucial for the effective delivery of safeguarding children services.

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References

- Appleton, J.V. and Stanley, N. 2009: Editorial: learning and training in safeguarding work. *Child Abuse Review* 18, 147–50.
- Balen, R. and Masson, H. 2008: The Victoria Climbié case: social work education for practice in children and families' work before and since. *Child and Family Social Work* 13, 121–32.
- Birchall, E. and Hallett, C. 1995: *Working together in child protection: Report of Phase Two: a survey of the experience and perceptions of six key professions*. Stirling: University of Stirling.
- Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J. and Black, J. 2008a: *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005*. London, UK: Department for Children, Schools and Families.
- Brandon, M., Belderson, P., Warren, C., Gardner, R., Howe, D. and Dodsworth, J. 2008b: The preoccupation with thresholds *Primary Health Care Research & Development* 2012; 13: 60–71

- in cases of child death or serious injury through abused and neglect. *Child Abuse Review* 17, 313–30.
- Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C. and Black, J.** 2009: *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005–2007*. London, UK: Department for Children, Schools and Families.
- Cameron, C. and Statham, J.** 2006: Variations in duty arrangements to respond to concerns about children's welfare. *Health and Social Care in the Community* 14, 167–76.
- Cantrill, P.** 2005: *In respect of children: executive summary*. Sheffield: Sheffield Area Child Protection Committee.
- Care Quality Commission.** 2009: *Review of the involvement and action taken by health bodies in relation to the case of Baby P*. London: Care Quality Commission.
- Commission for Health Improvement.** 2003: *Protecting children and young people – results of an audit of NHS organisations in England*. London, UK: CHI.
- Commission for Social Care Inspection.** 2005: *Safeguarding children. The second joint Chief Inspectors' report on arrangements to safeguard children*. London, UK: Commission for Social Care Inspection.
- Department of Health.** 2001: *Shifting the balance of power*. London, UK: Department of Health.
- Department of Health.** 2002: *Safeguarding children. A joint chief inspector's report on arrangements to safeguard children*. London, UK: Department of Health.
- Department of Health.** 2002: *Child protection responsibilities of primary care trusts – letter Jacqui Smith MP*. London, UK: Department of Health.
- Department of Health.** 2004: *The Chief Nursing Officer's review of the nursing, midwifery and health visiting contribution to vulnerable children and young people*. London, UK: Department of Health.
- Department of Health.** 2005: *Commissioning a patient-led NHS*. London, UK: Department of Health.
- Department of Health.** 2009: *Healthy Child Programme: pregnancy and the first five years of life*. London, UK: Department of Health.
- Department of Health.** 2010: *Equity and excellence: liberating the NHS*. Cm 7881. London, UK: The Stationery Office.
- Department of Health.** 2011: *Health Visitor Implementation Plan 2011–15 A Call to Action February 2011*. London, UK: Department of Health.
- Department for Education and Skills and Department of Health and Home Office.** 2003: *Keeping children safe – the Government's response to the Victoria Climbié Inquiry Report and Joint Chief Inspectors' Report safeguarding children*. London, UK: The Stationery Office.
- Department for Education and Skills.** 2003: *Every child matters*. London, UK: The Stationery Office.
- Department for Education and Skills.** 2004: *Every child matters: change for children*. Nottingham, UK: Department for Children, Schools and Families Publications.
- Dowswell, T., Wilkin, D., Kirk, S. and Banks-Smith, J.** 2002: Primary Care Groups and Trusts: a threat or an opportunity for the development of community-based nursing in England. *Journal of Nursing Management* 10, 283–89.
- Durfee, M., Durfee, D.T. and West, P.M.** 2002: Child fatality review: an international movement. *Child Abuse & Neglect* 26, 619–36.
- Glisson, C. and Hemmelgram, A.** 1998: The effects of organizational climate and interorganizational co-ordination on the quality and outcomes of children's service systems. *Child Abuse & Neglect* 22, 401–21.
- Glisson, C., Dukes, D. and Green, P.** 2006: The effects of the ARC organizational intervention on caseworker turnover, climate, and culture in children's service systems. *Child Abuse & Neglect* 30, 855–80.
- Hallett, C.** 1995: *Interagency coordination in child protection*. London, UK: Her Majesty's Stationery Office.
- Haringey Local Safeguarding Children Board.** 2009: *Baby Peter serious case review*. London, UK: Haringey LSCB.
- HM Government.** 2010: *Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children*. Nottingham, UK: Department for Children, Schools and Families Publications.
- Kanani, K., Regehr, C. and Bernstein, M.M.** 2002: Liability considerations in child welfare: lessons from Canada. *Child Abuse & Neglect* 26, 1029–1043.
- Kennedy, I.** 2010: *Getting it right for children and young people. Overcoming cultural barriers in the NHS so as to meet their needs*. London, UK: Central Office of Information (COI).
- Lachman, P. and Bernard, C.** 2006: Moving from blame to quality: How to respond to failures in child protective services. *Child Abuse & Neglect* 30, 963–68.
- Lambert, P. and Clibbens, K.** 2006: *NSCAN designated nurse survey*. Huddersfield, UK: National Safeguarding Children Association of Nurses Executive Committee.
- Lavrakas, P.J.** 1993: *Telephone survey methods. Sampling, selection and supervision*, second edition. London, UK: Sage Publications.
- Lincoln, Y.S. and Guba, E.G.** 1985: *Naturalistic inquiry*. London, UK: Sage Publications.
- Lord Laming.** 2003: *The Victoria Climbié inquiry. Report of an inquiry by Lord Laming*. Cm 5730. London, UK: Commission for Social Care Inspection.
- Lord Laming.** 2009: *The protection of children in England: a progress report*. London, UK: The Stationery Office.
- Lupton, C., North, N. and Khan, P.** 2001: *Working Together Or Pulling Apart? The National Health Service and child protection networks*. Bristol, UK: The Policy Press.
- Munro, E.** 2005a: Improving practice: child protection as a systems problem. *Child Abuse & Neglect* 27, 375–91.
- Munro, E.** 2005b: What tools do we need to improve identification of child abuse. *Child Abuse & Neglect* 27, 375–91.
- Munro, E.** 2010: *The Munro review of child protection. Part one: a systems analysis*. London, UK: Department for Education.

- Munro, E.** 2011: *The Munro review of child protection. Interim report: the child's journey*. London, UK: Department for Education.
- Musselwhite, K., Cuff, L., McGregor, L. and King, K.M.** 2007: The telephone interview is an effective method of data collection in clinical nursing research: a discussion paper. *International Journal of Nursing Studies* 44, 1064–1070.
- National Collaborating Centre for Women's and Children's Health.** 2009: *When to suspect child maltreatment*. London: RCOG Press.
- O'Brien, S., Hammond, H. and McKinnon, M.** 2003: *Report of the Caleb Ness Inquiry*. Edinburgh, Scotland, UK: Edinburgh and the Lothians Child Protection Committee.
- Ofsted.** 2008: *Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008*. London, UK: Ofsted.
- Ofsted.** 2009: *Learning lessons from serious case reviews: year 2*. Manchester, UK: Ofsted.
- Oppenheim, A.N.** 1992: *Questionnaire design, interviewing and attitude measurement*. London, UK: Pinter Publishers.
- Patton, M.Q.** 1990: *Qualitative evaluation and research methods*, second edition. London, UK: Sage Publications.
- Radford, J.** 2010: *Serious case review under Chapter VIII 'Working together to safeguard children' in respect of the death of a child case number 14*. Birmingham, UK: Birmingham Safeguarding Children Board.
- Rose, W. and Barnes, J.** 2008: *Improving safeguarding practice. Study of serious case reviews 2001–2003. Research Report DCSF-RR022*. Nottingham, UK: Department for Children, Schools and Families Publications.
- Sinclair, R. and Bullock, R.** 2002: *Learning from past experience – a review of serious case*. London, UK: Department of Health.
- Smith, E.** 2005: Telephone interviewing in healthcare research: a summary of the evidence. *Nurse Researcher* 12, 32–41.
- Sturges, J.E. and Hanrahan, K.J.** 2004: Comparing telephone and face-to-face qualitative interviewing: a research note. *Qualitative Research* 4, 107–18.
- The Children Act.** 2004: *Chapter 31*. London, UK: The Stationery Office.
- While, A. and Dyson, E.** 2002: Nurses' experiences of working in emerging primary care groups. *British Journal of Community Nursing* 7, 554–62.