Transitioning to a safeguarding children clinical network during a time of major NHS reform: an exploratory study about the experiences of Designated professionals

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ABSTRACT

Background: Safeguarding children is a priority area, yet the experiences of those statutorily charged with offering strategic direction and clinical leadership in health organisations has received little research attention. This study focuses on the experiences of Designated nurses and doctors as they transition from working as an organisation's sole expert to sharing tasks and responsibilities across many organisations as part of a countywide clinically-led Network.

Method: This qualitative study used a participatory action research methodology that allowed the author – a participant Designated nurse – together with colleagues to address concerns and ensure improvements during the course of the study. Data was collected at two points: during the consultation on the Network's form; and 12-18 months after its implementation.

Results: The first data, gathered when Designates were working as sole practitioners, illustrated their isolation, difficulties in accessing knowledge and anxieties about their capacity to respond to changing demands. Further analysis demonstrated that participants' experiences were shaped by local circumstances and the concerns raised by the newly announced NHS reforms. The second data set, gathered a year after the Network's launch and contemporaneous with the implementation of the NHS reforms, showed that team working had addressed most of their earlier concerns. The Network had legitimised sharing tasks, combatted isolation, improved access to new knowledge, and benefitted the professionals' authority through the reputation the Network had achieved for innovation in safeguarding. However, professionals raised concerns regarding collective responsibilities and individuals' accountability to the team.

Conclusion: The study's inability to completely separate the effects of this change in working practice from the NHS reforms limits its generalisability. The research offers insights into whether small groups of practitioners endeavouring to deliver scarce expertise to multiple organisations would benefit from a team approach, and whether voluntary participation and shared objectives are enough to sustain such teams.

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GLOSSARY OF ABBREVIATIONS AND TERMS

BMA	British Medical Association	Trade union/professional body for UK doctors
BPA	British Paediatric Association	1928-1996 when it became Royal College of Paediatrics and Child Health
CCG	Clinical Commissioning Group	Replaced Primary Care Trusts (Health and Social Care Act 2012), responsible for commissioning local area health care services
CQC	Care Quality Commission	Independent regulator of health and adult social care in England
DCSF	Department of Children Schools and Families	Replaced the Department for Education 2007
DE	Department for Education	Responsible for education and children's services in England
DES	Department of Education & Skills	As above 2001-2007
Designated professionals		England: Designated doctor and nurse required by CCGs
DoH, also known as DH	Department of Health	Created in 1988, responsible for policy on health and adult social care matters in England
DHSS	Department of Health and Social Security	Created in 1968 responsible for health policy replaced in 1988 by above
grey literature		e.g. some governmental policy, research and official reports in print or online, not controlled by commercial publishers
GMC	General Medical Council	Maintains and regulates register of medical practitioners within the UK
Hansard		Edited verbatim report of proceedings of both the House of Commons and the House of Lords
KPI	Key Performance Indicators	Metric used to evaluate factors crucial to service success
LSCB	Local Safeguarding Children Boards	Statutory functions: developing and scrutinising local arrangements (Children Act 2004)
LAC	Looked-after Children	A child is 'looked after' if in the care of the local authority for 24 hours+
MCN	Managed Clinical Network	Linked health professionals/organisations working in a co-ordinated manner, unconstrained by boundaries
NMC	Nursing & Midwifery Council	UK regulators of nurses and midwives: set standards for education, training, and conduct
NHS CB	NHS Commissioning Board	Rebranded NHS England, supports and develops effective commissioning
NIHR	National Institute for Health Research	A clinical research network in the NHS

PCT	Primary Care Trust	2001-2013: see CCG
RCPCH	Royal College of Paediatrics and Child Health	See BPA
‘Working Together’		Successive statutory guidance on UK inter-agency working to safeguard and promote the welfare of children

CHAPTER ONE: INTRODUCTION

In the English health system, the role of Designated professionals is one of the few required by statute. Since their inception over twenty-five years ago, their importance has been attested to by the successive strengthening of the role in governmental guidance (Department of Health and Social Security (DHSS) 1988; Department of Health (DH) 1991a, 1999a; Department of Education & Skills (DES) 2006; Department of Children, Schools and Families (DCSF) 2010; Department of Education (DE) 2013, 2015a). Yet there is negligible literature about these professionals (Peckover *et al*. 2015; Steele & Shabde 2014; Appleton 2012; Power 2008) or a body of knowledge which demonstrates their significance. The Named functions have been discussed (Polnay & Curnock 2003; Rowse 2009) and studies which look at child protection work by health staff mention Designated professionals but do not focus on them (Watkins *et al*. 2009; Crisp & Green Lister 2004).

This qualitative study, based on a participatory action research methodology, gathered the experience of Designated nurses and doctors – colleagues of the author – in one county. The research aim was to explore the Designated professionals' experience during a time when the conventional approach of a sole practitioner within one health organisation changed to collaborative working with other Designates across health economies within the Network. This was captured during two periods between 2010 and 2012 as the model was designed by the Designates, implemented and then embedded. This timeframe, however, coincided with the unexpected restructuring of the National Health Service (NHS) (DH 2010), and other changes which were to alter working relationships and demands on their posts.

1.1 The Designated professionals' role

Designated nurses and doctors (Designated professionals) specialise in safeguarding children in need of protection or those looked after by the local authority (LA). Designated professionals were customarily single doctor and nurse posts whose remit was to act as the strategic leads and expert advisers within the health economy area of a single Primary Care Trust[1] (PCT). The participating Designates were initially operating as sole practitioners.

1.2 The background to the study

The study took place in a geographically large county, which contained five PCTs, which later became seven Clinical Commissioning Groups (CCGs). At the beginning of the study, the countywide statutory agencies of Police, LA children's services and the Local Safeguarding Children Board[2] (LSCB) had been judged 'inadequate' by the joint Inspectorate (Ofsted 2009). This resulted in an improvement plan for child protection services scrutinised by government, and an increased prioritisation of child protection.

Nationally, at that time, the NHS reforms had been announced and a review into child protection (DE 2010a) was underway. Its author, Professor Munro, warned the Government to retain Designated professionals' skills in any future changes, noting that they '*would have an important role to play*' (DE 2010a:28). The unprecedented large-scale NHS structural reform was accompanied by debate and media coverage. Sir David Nicholson[3], NHS Chief Executive,

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[1] Primary Care Trusts later became Clinical Commissioning Groups and the responsibility to secure the services of Designated professionals transferred to them.

[2] Local Safeguarding Children Boards established by the Children Act 2004 (UK Parliament 2004/2006). Agencies cooperate together to safeguard and promote the welfare of children and hold each other to account.

[3] Sir David Nicholson was Chief Executive of the NHS from September 2006 until October 2011 and of NHS England from October 2011 until March 2014.

said of the reorganisation: *"It's such a big change management, you could probably see it from space"* (Nicholson 2010). Though he advised that *"no bit of the system is exempt"*, there had been no expectation that the changes would affect Designated professionals to the extent shown in the study.

The changed NHS architecture created the new bodies of the NHS Commissioning Board (later NHS England) responsible for specialist commissioning functions including General Practice, alongside CCGs who commissioned local services. Provider organisations (acute, community and secondary care) became separate legal and operational entities. This fundamental separation (or split) prompted individualised governance processes and Information Technology (IT) systems which affected information-sharing mechanisms.

1.3 The intervention

To address the criticisms raised by the Inspection and deal with increased demands, reduced capacity and structural reforms, the local delivery models for the Designated roles were reconsidered. Through a managed change process, the Designates discussed ideas about different ways of working, their preferred model being that of a network, an idea supported by the PCTs and partner agencies. The model meant Designates would remain employed by separate organisations, but for the first time were able to work across health agency borders, in a clinical network, to facilitate the joint discharge of statutory functions and develop a shared perspective on safeguarding children practice. The aim of the model was to resolve historical deficits in capacity, reconcile variations in strategic vision and practice, and develop an improved sustainable child protection and looked-after children service.

1.4 The need for evidence

The paucity of available research on Designated professionals' experiences might have an explanation in their small numbers. The legal requirement for England was for each of the 152 PCTs (221 CCGs) to employ a Designated nurse and doctor, but PCTs/CCGs could share Designates, owing to acknowledged difficulties in their recruitment. Studies found 30% of posts unfilled (Salari 2004; Lambert & Clibbens 2006) and a national survey (Care Quality Commission 2009) reported vacancies of circa 20%. While no central point collects data on the numbers of Designates, there appeared still to be a shortfall, as evidenced in the Parliamentary select committee which recorded that posts were "diminishing" (House of Commons 2012:70). Given that these remain statutory posts, it is essential to understand the demands on these professionals and the ways in which their work could be organised and delivered to better augment their limited resources.

1.5 The research questions

The aim of this research was to explore the experience of Designated professionals as they changed to working collaboratively. This took into consideration whether working in a network altered the nature of the benefits, stresses and concerns which professionals reported. The study also explored if their experience had been impacted by the Network's[4] normalisation of seeking support, advice and knowledge from colleagues. The study adopted a participatory action research approach, in which data collection took place in two phases, one during the managed change process and the second twelve to eighteen months after the Network's launch.

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[4] Capitalisation of the word Network applies only to the intervention at the study's centres, and corresponds to the name given to it by the participants. To differentiate, lower case is applied when referring to networks in general.

The research questions for the first phase enquired:-

Would team working address the challenges?

What abilities and capacity did Designates need to address the demands?

What were the Designates' wider concerns?

The research questions for the second data collection phase sought to investigate how the Designates were experiencing their role since the Network's introduction and asked:-

Had collaboration assisted with the challenges they and their service faced?

How had Network membership affected their abilities and how they worked?

What new issues had impacted the professionals since the Network began operation?

1.6 Outline of thesis chapters

This introductory chapter provides the rationale for the thesis which is organised into seven chapters. Chapter two reviews wider extant literature including academic, legislative, governmental policy and guidance. A range of literature was reviewed to aid understanding of how the intrinsically emotive and high-profile societal context of child abuse affected public and professional attitudes and beliefs over time. This includes the position that children occupy in English society; the gradual expansion of society's responsibility for safeguarding children; and the effects of media coverage on society's responses. Literature specific to the NHS child protection services and Designates' roles was reviewed, alongside that of their organisations' accountability frameworks and the 2012 NHS reorganisation. Literature on the theories of change management was also considered.

Chapter three discusses and critiques the epistemological underpinnings relating to the methodological choice and provides a detailed description of the research design. A qualitative methodology (Saks & Allsop 2007) which drew on participatory action research (PAR) (Koch & Kralik 2006; Reason & Bradbury 2006; Reason 2004; Stringer 2007) was chosen for the study. Three defining qualities recommended this methodology as appropriate: firstly, the non-reliance on a prior theory or body of knowledge; secondly, the flexibility of approach with the aim of discovering the meaning to the Designates of their experience. The significance of this flexibility was demonstrated as it responded to the Designates' high levels of stress reportedly caused by the unexpected NHS reforms. The third attribute was its emphasis on action to change and improve practice.

Chapter four analyses the data collected from historical records of the consultation and formal managed change process. This process enabled the Designates to shape the Network's structure, operating procedures and principles and the data catalogued their pressures and concerns. The chapter reflects the landscape of uncertainty and records the Designates' worries regarding the impact of their separation from frontline practice. Chapter five analyses the data collected through semi-structured interviews with Designated professionals after the Network model had operated for over twelve months.

Chapter six considers whether the study's findings have answered the research questions. Six overarching findings which highlighted the Designates' experiences across the data are used to illustrate the interpretations from both phases of the study. Literature was used to refute, validate or add perspective to the discussion, which endeavoured to move forward the professional debate on delivering the statutory roles by way of networks. The chapter considers the implications of the operational changes, the significance for practice and the effectiveness of the Network. These are reviewed using some of Turrini *et al*.'s (2010) indicators. The Network's drawbacks and limitations are discussed and the sustainability and viability of networks are considered to assess whether the corporate processes for managing networks' resources act against the need of sole practitioners to form groups to provide them with professional support. The thesis concludes in chapter seven where consideration is given to the implications of the findings and recommendations made to benefit service users by changes in organisational arrangements and Designated professionals' practice.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The Designated professional roles are unique to the British National Health Service[5] (NHS), and this is reflected in the concentration of British literature reviewed. No studies were found which shared the same precise focus of Designated professionals' experiences during a change process which formed their working practice into a network. The paucity of literature continued when the search was widened to include Designates' responsibilities and place in the health economy. Searches were made of legislation, governmental public policy, and both generic and specific guidance on child safeguarding, which was pertinent as the research occurred during a period of intense external change. Other areas assessed included the assumptions about children's place in society, and the media's semiotic representations of children, child abuse, and the portrayal of child protection workers. Managed change theories were reviewed, as were transformational and transactional change and leadership. Literature on networks in health care and the implications of clinical supervision and knowledge acquisition were appraised.

The qualitative methodology chosen necessitated an ongoing and flexible approach to the review of literature, which extended into areas that had not been predicted at the outset. The tangential review of literature from other fields of study complemented the study's focus of the Designates' experiences. This included literature from the disciplines of

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[5] In England Clinical Commissioning Groups are required to have a designated doctor and designated nurse. Public Health Wales has a structure of Designated and Named professionals. Each Northern Irish Health and Social Services Trust has designated professionals for child protection. In Scotland, there are lead paediatricians and consultant/lead nurses (RCPCH 2014:4).

philosophy, sociology and psychology and in complexity theory, decision-making and aspects of journalism.

2.2 Search strategy

An obstacle to locating key texts on the review’s focus was the ubiquity of the term 'designated'. This term is used across many fields, including in medical and nursing studies where it is used in areas unrelated to child safeguarding. Within literature on safeguarding, the term ‘designated’ was often used as a verb, rather than as a title for specific posts. Searches elicited large amounts of research on various aspects of child protection, categories of abuse and agencies’ interventions, and, while examined, most bore no relevance to the study’s specific criteria.

Electronic searches used specific Health and Social Science databases, including Medlineplus[6], CINAHL (Cumulative Index to Nursing and Allied Health Literature) and JSTOR (Journal Storage). Searches were iterative with combinations of terms used to widen and narrow the field in an endeavour to elicit materials. The main search terms used were ‘Designated nurse/doctor’, ‘network’ and their synonyms (specialist, collaborative etc.) and in combination with the terms ‘child protection’ or ‘child safeguarding’ they resulted in large numbers of documents. Though few focussed on Designates’ experiences, there were studies on paediatricians’ engagement with child protection (Mathews *et al*. 2009), nurses’ referral of child abuse (Natan *et al.* 2012; Dixon *et al*. 2004) and the development of

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[6] incorporating National Library of Medicine and National Institute of Health

paediatric care networks (Court 2004; Cropper *et al.* 2002). Although peripheral to the study, these studies were reviewed.

Alternative strategies, including hand searches, were used to search for hard-to-reach materials and identified studies' references were scrutinised which generated literature not found on electronic searches. Publishers of practice-specific journals such as Wiley Online and Science Direct were individually searched; these highlighted topics such as game and complexity theory that were beneficial for background reading. Newspapers, professional magazines and 'grey literature'[7] were reviewed, as they contained much commentary on health professionals' role within child protection and the NHS 2012 restructuring. All aspects were examined to understand the context in which Designates experienced and sought to discharge their role.

2.3 The construct of childhood

Childhood as a social construct is constantly refashioned by our engagement with and alterations to the idea of what constitutes and affects children's lives (Green 1997; Cunningham 2006). Attitudes towards childhood and social expectations of children are embedded in the prevailing culture and show remarkable plasticity, with changes happening imperceptibly or seismically in response to society's censure. James & Prout (1997) suggest children's place in western society was established when the state and its institutions began

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[7] 'Grey literature' includes governmental, policy or research reports, conference papers and official reports in print or online, not controlled by commercial publishers.

to use statistical thinking[8] (Snee 1990) to count and categorise populations. Children became identified by their conditions, health, education, or problems such as delinquency, truancy, neglect or abuse, and, once recognised, society developed interventions to treat or regulate. The sociologist André Turmel suggests that it was scientists and politicians, who in 'the century 1850-1945' framed the modern '*development paradigm'*[9] (2008:2), particularly in the field of 'child welfare', where morbidity and mortality rates were used as indicators of the state's ability to keep children alive and healthy.

While today the majority of children are healthy and treasured there will be a minority of children who are disadvantaged, unloved or abused, though how abuse is viewed is modified by society's concept of childhood. In Britain the idea of childhood appears still to be influenced by the highly ambivalent Victorian view, which veered between the child as a villain, hero, commodity or cherub. Millais's iconographic painting 'A child's world' shows a cherubic boy as *'innocence personified'* (Paxman 2009:143). This image so appealed to the public that it was commodified by Pears soap for their successful advertisement 'Bubbles', and it still engages audiences today. However, the Victorians also saw '*aesthetic purity*' in a fashion for photographic collections of '*naked young girls posed erotically*' (Cunningham 2006:152). Though that aesthetic is viewed differently today, the paradox exemplifies a more general cognitive dissonance within society's view of children.

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[8] Statistical thinking refers to thought processes which recognise that variation is in everything. By identifying, characterising, controlling and reducing variation it provides opportunities for improvement (Snee 1990:118).

[9] Turmel suggests that childhood is understood as a social construction and not just as a natural and universal phenomenon. The 'development paradigm' supported a socially constructed view of childhood as it saw the child as a 'being in development' as promoted in Charles Darwin's influential 'A Biographical Sketch of an Infant' (Darwin 1877). This encouraged parents to observe, record and compare children's development and for interventions to be sought if children deviated from the accepted norms.

The first Children Act in 1889 also saw the creation of the National Society for the Prevention of Cruelty to Children (NSPCC) and health visiting's forerunner the Manchester and Salford Lady Visitors (Thornbory 2009:47) and it was their unsentimentalised first-hand accounts which is seen as driving the welfare agenda. Ferguson (2011) argues that such organisations legitimised professionals' inspection of people's homes. In so doing they broke the barrier between the privacy of home and the domain of professionals and normalised the routine work of health and social workers. Together with the welfare state, these changes created an expectation that the state would intervene to stop things going wrong, and therefore could be blamed when they did (Ferguson 2011). Ferguson notes historically this was not the case, as seen in the NSPCC's early uses of child death statistics as proof of their success: *'there was no shame for workers involved in cases where children died, when they had done their best to protect children'* (*ibid*:24). This differed from today's notions of public accountability[10] and responsibility for failure which feature in health professionals' fear of being named in association with a child abuse case.

Turmel suggests that, as mortality rates reduced, the baton passed to psychologists to define the 'normal child and family' and by what measures to judge when society should intervene. Dr Winnicott was a British paediatrician and psychoanalyst whose BBC broadcasts in the 1960s and bestselling books profoundly influenced thinking. Together with his wife, a social-work teacher, they developed the concept that most parents were devoted to their children and, while not perfect, most were '*good enough*' (Winnicott 1953). This idea was to become a cornerstone for family work, as it acted to delineate children for

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[10] Public accountability: 'The obligations to present an account of and answer for the execution of responsibilities to those who entrusted those responsibilities' (Gray & Jenkins 1993:55).

whom parenting was not ‘good enough’ and in whose lives the state should intervene. The interventionist approach relied on an expanded concept of parenting which included not just the relationship between child and parents, but also the wider society.

In health today’s interventionist narrative on child protection has its genesis in the ‘Battered child syndrome’ (Kempe & Helfer 1968). Promulgated by the American paediatrician, Dr C Henry Kempe, it took a different view to Winnicott. Kempe wrote ‘*It is regrettable our concept of mothering is so influenced by our idealised view*’ noting that one in five parents would have ‘*serious problems… requir[ing] a great deal of support*’ (1971:30). Kempe, in collaboration with the British Paediatric Association[11] (BPA), produced a ‘memorandum on battered babies’ (British Medical Journal (BMJ) 1966). Later, for the BPA’s conference, Dr Kempe published the ‘Paediatric Implications of the Battered Baby Syndrome’, in which he revisited his earlier view that the ‘*principal concern of the physician is to make the correct diagnosis so that he can institute proper therapy*’ (Kempe 1962:111).

Dr Kempe’s influence appears to have shaped how health professionals view their role in child protection. Kempe’s use of the words ‘battered’ and ‘syndrome’ indicated a doctor’s duty was to use their medical knowledge and investigations, such as X-rays, to the diagnosis and treat abuse. This narrow view of a doctor’s responsibilities is still seen in literature (Nathan *et al*. 2012), and while Kempe’s medical approach was consistent with an American mandatory reporting model, it left doctors at variance with the British principle that each professional take responsibility for keeping children safe (Mathews *et al.* 2012).

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[11] The British Paediatric Association (BPA) formed in 1928. The association received Royal College status in 1996 and became the Royal College of Paediatrics and Child Health (RCPCH).

2.4 Child protection policy, legislation and professionalisation

2.4.1 Child protection in the NHS

The shock of a child murder is often the catalyst which changes the public's perception on child abuse and leads to new legislation. The first of these was the death of Denis O'Neill in 1945, which prompted a public demand for change. The government response, the Curtis Report, has been cited as having significantly influenced the drafting of the 1948 Children Act (Sidebotham & Fleming 2007:233) as it coincided with the beginnings of the welfare state which '*ushered in a new enlightened age in which families would be helped to stay together*' (Parton 2002:11).

The first inquiry to highlight the failures of professionals and child welfare agencies was into the death of seven-year-old Maria Colwell in January 1973 (Department of Health and Social Services (DHSS) 1974). Maria, brought up in foster care, had been reunified with her family for less than a year when she was beaten to death by her stepfather. The DHSS issued 'Non-Accidental injury to children' (1976), a seven-page list of voluntary recommendations, including the introduction of formalised procedures, multidisciplinary Case Conferences and local Child Protection Registers (Sidebotham 2012:189). This circular, with additions and amendments, remains the basis for the system seen in health today.

There were a further twenty-nine child homicide inquiries between Maria's death and 1984 when consecutive inquiries into the deaths of three little girls imprinted themselves on the public consciousness (Lonne & Parton 2009:31). Three-year-old Heidi Koseda in 1984, and four-year-olds Jasmine Beckford in 1985 and Kimberley Carlisle in 1986, all shared similar histories in which, despite agencies being aware of their situations, the girls died starved and beaten at the hands of their parents. The inquiries highlighted the need for coordinated interagency working, the prioritisation of child protection work, and for regulatory processes (Corby 2002) and questioned health's role:

> *'the death of Jasmine Beckford was both a predictable and preventable homicide… The blame must be shared by all services (health, education, social services …) in proportion to their various statutory duties'* (Beckford inquiry: London Borough of Brent 1985:287).

Reder *et al.* thought the report's accusatory style and adversarial frame created a defensive approach, which stopped practitioners examining their own practice. They wrote:

> *'Statements such as this were contrary to our clinical approach and way of thinking and had more the tone of judgment'* (1993:2),

while Professor of Social Work Olive Stevenson, member of the Colwell inquiry, supported the report stating '*there can be no defence of professional practice which loses sight of the primary focus of concern – child protection'* (1986:501). Perhaps as a portent of a blame culture taking root in the professionals' psyche, the debate shifted to who was at fault.

During the Cleveland 'scandal'[12] child protection professionals underwent intense media scrutiny and in the face of media attempts to find someone to blame, interagency working retreated. Lady Justice Butler-Sloss's inquiry found *'no single agency... had the pre-eminent responsibility in the assessment of child abuse generally and in child sexual abuse specifically'* (Department of Health (DoH) 1988b:251).

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[12] Cleveland centred on a five-month period in 1987, when 121 children were removed from their homes following suspicions they were being sexually abused (Department of Health 1988).

2.4.2 The Children Act 1989

In 1988 when the Lord Chancellor presented the Children Bill in Parliament he noted there had been a "*sharply increased public concern over the care, protection and upbringing of children… generated by recent events*". He stated that the Bill "*represents the most comprehensive and far-reaching reform of child law*" and gave the state the responsibility to "intervene in private family life on behalf of the community in order to help the children" (Hansard 1988 502:496). In the same debate Lord Mischon referred to the inadequacies in interagency working and the media's portrayal of incompetence in "*scandalous cases*" (*ibid*:497). The Act was accompanied by the first Interagency guidance which specified 'specialist doctor and nurse roles' (DHSS 1988); this was expanded to include detailed descriptions of their responsibilities in the first 'Working Together' guidance (DHSS & Welsh Office 1988 5.50-5.53).

The revised Children Act (United Kingdom Parliament 1989) set the criteria for state involvement by defining what constituted 'significant harm'. 'Working together under the Children Act' (DoH 1991a) issued the strong but non-statutory guidance that each '*Health Authority should identify a senior Doctor and a senior Nurse with Health Visiting qualification'* (*ibid*:18) to assist and advise on procedural and clinical matters, and created the 'Designated' nomenclature. The Designated professionals' remits were later separated and expanded (DoH 1992). Following a government commissioned study 'Messages from Research' (DoH 1995a) and new regulations (DoH 1995b), Designates' responsibilities were extended into interagency roles and medical responsibilities were clarified (DoH 1996).

The 1990s were a quiet time for policy reform as inquiries into individual child deaths ‘went underground’ with Part 8 Reviews[13] conducted locally and not published (Stanley & Manthorpe 2004). There were ten inquiries into institutional abuse in the 1990s, culminating in the largest public inquiry into Clwyd’s children’s homes: it made 72 recommendations (DH 2000b) but government took no action. This changed in 2012 when Operation Pallial re-examined the inquiry and culminated in 18 arrests and prosecutions (North Wales Police 2013).

The revised ‘Working Together’ guidance (DoH 1999a) was the last to be issued without the full force of statute, but despite this ‘*given the political sensitivity of the area... considerable operational weight was attached to these circulars of guidance’* (Lupton *et al*. 2001:34). The guidance broadened the remit of child protection work to ‘*looking after and promoting the welfare of children*’. This again extended the Designates’ remit to include supporting Acute and Mental Health services to ensure all child contacts had a safeguarding focus.

2.4.3 Victoria Climbié reforms

Lord Laming’s inquiry into the death of eight-year-old Victoria Climbié in 2000, resulted in a seismic shift in policy (Secretaries of State for Health & the Home Office 2003). Similar to previous Inquiries, Victoria’s history was of being starved and beaten to death by her aunt and aunt’s boyfriend, despite the fact that Police, Housing and a social worker had all visited the home. The report made 108 recommendations, 36 specifically for Health. His report shaped the Children Act 2004 (UK Parliament 2004) which established Local Safeguarding

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[13] Part 8 of the ‘Working Together’ guidance gave partners in England information-sharing powers with other agencies for the purpose of investigating serious child abuse and child death cases.

Children Boards (LSCBs), the Care Quality Commission (CQC) and framework for Ofsted inspections and made cooperation between agencies a ‘statutory duty’.

The Inquiry’s statement that ‘*little suggests that monitoring of performance in relation to protection of children at a local level in the NHS has been much developed’* (2003:17.69) saw the idea of performance monitoring gain strength. The policy agenda ‘Every Child Matters: Change for Children’ (ECM) (DCSF 2005) was outcome-focussed. This national framework improved information, specified targets and created indicators to monitor practice and outcomes, an example being the statistical mandate to report the number of children on the Child Protection Register[14]. While this changed working culture, in retrospect, ECM indicators took no regard of the difficulties of achieving positive outcomes, being as they were as dependent on changing parental behaviour as on practitioner’s actions.

> ‘*The collection, classifying and management of information have taken on a strategic significance for both safeguarding… and holding professionals to account… work has become managerialized’*. (Lonne & Parton 2009:51)

The changes in the agenda not only refocussed how health professionals were expected to respond to child protection, but the accompanying revision of ‘Working Together’ (DES 2006) put responsibility for making that happen on to Primary Care Trusts (PCTs):

> *‘The term “designated professionals” denotes… specific roles and responsibilities for safeguarding children. All PCTs should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the PCT area, which includes all providers’* (2006:58).

It went on to say that Designates had ‘*an important role in promoting, influencing… skilled professional involvement in child safeguarding processes*’ and that NHS Trusts and PCTs ‘*providing services for children [should] identify a named doctor and a named nurse*’ (*ibid*

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[14] A local authority database recording children deemed legally 'in need of protection'.

2.61) (Appendix 1). The job descriptions and competences for Designated and Named roles were specified by the Royal College of Paediatrics and Child Health (RCPCH 2005).

2.4.4 Peter Connelly reforms

The Court case and first Serious Case Review[15] (Haringey LSCB 2008) into the death of seventeen-month-old Peter Connelly aroused huge media coverage, and the government responded by commissioning Lord Laming to relook at the English child protection system. On completion he stated '*the need to protect children… is ever more challenging. There now needs to be a step change in the arrangements to protect children from harm'* (House of Commons 2009:3). He warned:

> '*The wariness of staff throughout the health services to engage with child protection work. GPs, community nurses and paediatricians must be helped to develop a wider range of skills and become very much more confident*' (House of Commons 2009:6).

To the backdrop of a doubling in the number of referrals of children with signs of child abuse, Lord Laming's recommendations to reinforce the need to share information (DCSF 2008) and the duty to cooperate (DCSF 2009a) were accepted. The CQC strengthened the message further and provided 'leverage' by specifying that '*safeguarding and promoting the welfare of children*' should be at the core of all services and the posts of Designated and Named nurses and doctors were 'a legal requirement' (CQC 2009). The Health and Social Care Act (UK Parliament 2008), applicable across the NHS and independent healthcare sector, incorporated the recommendations within a regulatory framework. The amended 'Working Together' (DCSF 2010) guidance and Intercollegiate document (RCPCH 2010),

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[15] Serious case reviews (SCRs) are undertaken by local safeguarding children boards (LSCBs) for every case where abuse or neglect is known or suspected and either: a child dies; or a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child (DE 2015a).

reiterated that the Designates' role should '*take a strategic, professional lead … across all the PCT area*' (DCSF 2010:67) and detailed the training and competency requirements for all NHS health staff including Board members.

2.4.5 The 2010 agenda

The immediate years leading up to 2010 had seen an expansion in both the demand on child protection services and the public's and government's expectations. The change in governing party also saw a change in the safeguarding children agenda, with the ending of the cross-cutting ECM programme and a promise to '*publish serious case reviews*' (Cabinet Office 2010:20). This overturned a twenty-year tradition of the anonymity for workers, which initially had an unfavourable effect on interagency information sharing. Concern were expressed in Parliament that the policy would have a negative impact because of the "*media who are obsessed with the blame game*" (Hansard 2011:359).

Professor of Social Policy Eileen Munro was asked in June 2010 (DE 2010a) to re-examine the child protection system in England. Her report commented that the '*cumulative impact of reforms has contributed to a heavily bureaucratised, process-driven system*' (DE 2011:15) with '*burdensome rules and guidance*' (*ibid*: 137) that created the unintended consequence of poor and stifled practice. Simultaneously the Department of Health released the White Paper 'Equity and Excellence: Liberating the NHS' (DH 2010), which proposed a root-and-branch NHS restructure. Though the paper indicated that safeguarding duties were to pass to 'GP Consortia', the document's lack of detail left practitioners uncertain of their service's future. These proposed changes prompted public debate and it was testimony of the professionals' concern when, in August 2010, the union Unison applied to the High Court for a Judicial review of the proposal.

The white paper's negative reception prompted the government's unprecedented decision to '*pause, listen, reflect and improve'* the NHS reform plans (Mullholland 2011). The details of the changes remained unspecified for nearly two years until interim advice was published which stated that safeguarding responsibilities would pass to the local NHS Commissioning Boards (NHS CB 2012) and Clinical Commissioning Groups (CCGs). It was not until one week before the implementation of the Health & Social Care Act (UK Parliament 2012) on the 23 March 2013 that the Accountability Framework (NHS CB 2013) and the revised statutory 'Working Together' (DE 2013) were published. For Designates, the restructure completed the split between them as commissioners and frontline staff in providers.

2.4.6 Role expansion

One specific area in which the Designated nurses' role expanded was their direct responsibility for General Practitioners (GPs). GPs are specifically named within many safeguarding policies, as having '*a vital role to play in the protection of children*' (DoH 1991a:20; Lupton *et al.* 2001). However there was also '*widespread dissatisfaction with GPs' role in child protection*' (Simpson *et al*. 1994) from partners. A Government report on the state of interagency working found:

> '*GPs are rarely involved in child protection and a large number of them know little about the system. Whether they should know more and be drawn in more closely is an important point for their profession and policy-makers'* (Hallett & Birchall 1992:235).

The 2009 CQC review of safeguarding arrangements gave responsible for improving GPs' safeguarding competencies to the Designates nurses. This was supported by 'Working Together' (DCSF 2010) which created the Named GPs role to act as advisor to colleagues and strategic advisor to commissioners. However, the scope, complexity and scale of this responsibility for Designates was unexpected and added to their increased workload.

The expansion of safeguarding children policy and legislation had a significant bearing on the study and its focus on the experience of Designated professionals. While Designates saw their position strengthened, they also saw the expectations and accountability regarding their and others' practice heighten. In the next section I will examine how media reports on landmark cases may have influenced the prevailing narrative and therefore the context in which Designates operated.

2.5 Media reporting of child protection

The media uses a rational linear perspective to report child protection stories, which relies on a 'crime – blame – punishment' narrative to make them newsworthy (Kitzinger 2000). Certain events have caused intense media scrutiny which appears to have affected public perceptions of child abuse and created expectations of health professionals.

2.5.1 Maria Colwell and Dr Kempe's work

The media coverage of Maria Colwell's murder trial in 1973 used the dual points of interest of her stepfather's abuse and professionals' failures to capture the public's attention. In a speech on the Colwell Inquiry's opening day, 'Sir Keith Joseph[16] specifically linked the work of the NSPCC [Battered Child] Research Unit… and the work of Henry Kempe' (Butler & Drakeford 2011:141). As the Inquiry continued The Times newspaper used the campaign title 'Battered Babies' to call for changes in the law, and reinforced this connection in their report of the speech. How these links were made appears complex, but it seems that one fundamental aspect was Sir Keith's perspective that:

> "*The balance of our population, our human stock is threatened… a rising proportion of children are being born to mothers least fitted to bring them up… mothers in social classes 4 and 5… unmarried… [and of] low intelligence*" (Joseph 1974).

His controversial view on the potential for intergenerational abuse and the focus on physical abuse resonated with the paradigm espoused by Dr Kempe and the NSPCC at that time.

Parton suggests rather than simply reporting the crime the press '*took a far more active, campaigning, crusading role'* (1979:441) which focussed on the failings of the state:

> '*The enquiry formed a regular item in the press and on TV news programmes, so that by the time the report… was published… the issue was established as a major social problem requiring formal intervention'* (1979:442).

The attention gained by the 'Battered baby' campaign's focus on physical injury legitimatised a socio-medico view of abuse. Once defined as an interventionist model, reliant on doctors' technical skills, it may have limited and predestined how health professionals saw their role in child protection. Goddard & Liddell suggest '*media attention to Kempe's work allowed his research to be granted the seminal status*' (1995:356) and its repetition in the extensive coverage may have moulded perspectives.

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[16] Secretary of State for the Department of Health and Social Security and author of the National Health Service Reorganisation Act of July 1973.

2.5.2 Cleveland and the narrative of blame

The media uses '*rare hazards rather than commonplace events*' (Gough 1996:366) to secure the public's attention and this finds a rich seam in child abuse stories. Presented in terms of a clash between the corrupt and the innocent, reports allow the reader to sense there is a divide distancing them from the perpetrators. The media reports extremely rare abuse, '*child murder, sex rings… [which] encourages the development of moral panic*[17] *and over-sensitises people to the risks*' (Gough 1996:366). Such characterisation obscures the most common danger, the family itself (Kitzinger & Skidmore 1995). In response to this type of media coverage, the public looks to blame either the abuser, who they view as abhorrent and remote, or the workers, who as the public's proxy are more culpable.

The media reports of the Cleveland 'scandal'[18] emphasised poor medical practice by paediatricians (DoH 1988a). The calumniating press reports castigating the doctors had a long-lasting negative effect on doctors' engagement with cases of suspected child sexual abuse (Edwards *et al.* 2002). This may be understandable given that The Sun resurrected the story after twenty years with the headline, 'Abuse scandal's shameful legacy'. Reasserting the belief that their practice was wrong, and accusingly stating that 'Dr Higgs and Dr Wyatt still work in children's medicine' (Holt 2007), the story included their locations and personal details, for reasons which could only be viewed as intimidatory.

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[17] 'Moral panic' is a suddenly emergent phenomenon seen as a threat, which can be caricatured by the mass media (Cohen 2002).

[18] The story centred on the controversial use by paediatricians Dr Higgs and Dr Wyatt of the 'anal dilation test', developed by them as a diagnostic tool for child sexual abuse.

2.5.3 Portrayal of health professionals

Professor of Journalism Jenny Kitzinger describes the way Cleveland set a framework for interpreting other ‘scandals’ such as Orkney[19] (House of Commons 1992) four years later. She contends journalists’ linked the events in reports to show a ‘*pattern of malpractice threatening ordinary families’* (Kitzinger 2000:65). Kitzinger states ‘*Its symbolic power lay in its status as a template’* (*ibid*) and its legacy was to ensure future stories construed professionals as the perpetrators of wrongdoing in the public’s mind. The interpretative frame once set ‘captures the zeitgeist’ to harnesses previous sentiments which blames practitioners, and ignores child abuse’s complexity.

Particularly damaging media vilification was seen in the case of Professor Roy Meadow[20], who the court of appeal judged had given misleading and flawed statistical evidence. He was struck off the General Medical Council (GMC) register, but on appeal he was reinstated. However the media coverage overshadowed his career for seven years (Dyer 2005; Clark 2005). Similarly with Professor of Paediatrics and child protection specialist Dr David Southall[21] the GMC branded him ‘*a very dangerous doctor*’ in 1999. He was struck off, cleared, reinstated, struck off again, and finally reinstated by the Court of Appeal in 2012. Dr Southall had been ‘*14 years in the rifle sights of the General Medical Council*’ (Dyer 2012 314:e3377). Dyer noted the unintended consequences of negative reports impairs rather than improves services, as it affects doctors’ willingness to be involved in child protection.

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[19] In 1991 nine children were removed by social services who suspected ritual abuse. All were later returned.

[20] Dr Meadows gave expert witness testimony in the trial of Sally Clark stating two cot deaths in one family had a 1 in 73 million chance of occurring naturally (Kelso 2000).

[21] Dr Southall’s pioneering work on Fabricated and Induced Illness by Carers used video surveillance methods, this led to him being accused of ‘experimenting’ on children.

> '*Paediatricians who see what happened to one of the leaders of their profession are loath to put themselves in the firing line and the numbers willing to do child protection work have dropped'* (*ibid*).

The GMC published the guidance 'Protecting children and young people: the responsibility of all doctors' (GMC 2012) in response to the lessons learnt from these cases. However, media coverage and negative public opinion affected professionals' confidence, and this BMJ editorial is resonant of Kempe's defensive model of child protection work:

> '*It is not for the doctor to decide what is in the child's best interest, but it is the doctor's job to see that the court is given a chance to make that decision. Many paediatricians are becoming increasingly reluctant to become involved… [due to] adverse media publicity'* (Hey 2003:299).

Child abuse and child protection failures are embedded in the public's mind as stories of interest, and while all would agree that the public has a right to expect good services, it is debatable if the one-dimensional negative media template has driven standards up. While the five years from 2007 to 2011 saw the number of children placed on child protection plans rise (DE 2015b), studies and government documents (House of Commons 2009; CQC 2009; Davies & Ward 2012) point to the reluctance of professionals to choose this work, with one study finding only 14.7% of paediatricians willing to do so (Zalkin *et al*. 2011).

2.6 Change management

The review found extensive literature on management theory and its component elements from strategies, finance, workforce, training, development and change. Many studies focussed on wealth producing systems, with smaller numbers concentrating on the non-profit sector. Across all, Burnes found that a '*bureaucratic approach to organisations [was] the most appropriate and efficient*' (1996:36). Organisational structure generated many studies, with Mintzberg's classification of 'Professional bureaucracies' (networks) and

‘Strategic apex’ (hierarchies) (Johnson & Scholes 1999:434) often quoted. A view across theories appears to be that the ‘*most important resource of an organisation is its people so how people are organised is crucial to the effectiveness of the strategy*’ (*ibid*:401).

The way organisations engage their workers is important to the study and such work as Drucker’s advocacy of ‘workers’ as the drivers of quality and innovation and their centrality to an organisation’s success is directly applicable. Drucker stated: ‘*The most valuable asset of a 21st-century institution, whether business or non-business, will be its knowledge workers and their productivity*’ (1999:135). Peters & Waterman (1982) echoed similar principles: though they showed hierarchical structures maximised profit, they reiterated the principle that an organisation is only as good as the people who work for it.

Most management theories address managing change as part of the organisation’s strategy (Kotter 2012; Anderson & Anderson 2010; Blanchard 2007; Drucker 1999; Bridges 1991). The difficulty in reviewing its literature has been the variety of fields which contributed to it, including psychology, sociology, and business. Many studies are ‘how-to’ narratives for industry and their focus being on embedding change (Blanchard 2007; Peters & Waterhouse 1982), while fewer studies sought to draw evidence from change. Stewart & Kringas (2003) noted that change in public bodies was often not researched as it was labelled ‘reforms’ and dismissed as ‘administrative’ which is seen in some NHS funded studies (Currie *et al*. 2010). Sirkin *et al.* (2005) suggest that the ‘hard’ facts of manpower, the financial resources and time, to make change happen, should be addressed simultaneously with the ‘soft’ elements of leadership, culture, communication and motivation. While they warn that change fails two times out of three (Sirkin 2005; Beer & Nohria 2000), Reichers *et al.* (1997) note that a high frequency of change can generate cynicism which hinders staff's ability to engage.

The work of Kurt Lewin links change management theories to action research: '*There is little question that the intellectual father of contemporary theories of applied behavioural science, action research and planned change is Kurt Lewin'* (Schein 1988:239). The Lewinian traditions share the idea that in 'normal' conditions behavioural change is slow, but in more volatile conditions '*established routines and behaviours break down and the status quo is no longer viable; new patterns of activity can rapidly emerge and a new equilibrium is formed*' (Burnes 2004:982). Pettigrew *et al.*'s comparative study in sixteen hospitals (1992a) concluded that the success of managed change was highly contextual, and receptivity to change was increased by factors such as significant large-scale external pressures.

The NHS Executive recognised delivery of care could be improved by supporting staff and organisations to change they stated '*Change may be an imprecise science, but evidence is available on what works and what does not, and the NHS must make use of is*' (1998:2). The NHS Service Delivery Organisation (NHS SDO) published a literature review to encourage the use of change management techniques and answer the why, who, what and how questions by illustrating approaches and tools available (Iles & Sutherland 2001). There followed case studies which highlighted issues and the skills required to counter the problems (Iles & Cranfield 2004). The NHS Institute for Innovation and Improvement took this forward and offered an online library of tools and accounts of the implementation of change at the frontline of healthcare (2008). The National Leadership Council (2011) states it is everyone's duty to improve care, and that implementation of change is a clinical leader's role. This was examined in a survey study of 480 registered nurses in acute care by Patrick *et al*. the findings of which showed 'encouraging support' (2005:458) for the notion of nurses as key transformational leaders.

2.6.1 Transformational and transactional change

The early ideas on transformational and transactional change can be seen in Burns' (1978) study of political leaders where the positive and valuable changes which occurred were attributed to the differences in styles. These ideas were developed by Bass (1985), where he suggests that once change could no longer be achieved through the legitimate and coercive powerbase of master/servant, more transactional relationships were developed to bring about the change or task required. Bass stated transactional leaders exchange tangible or intangible resources such as promises of advancement, pay or penalties, for followers' performance. Bass suggests the transactional change's focus on standard setting and monitoring for deviations delivers mediocre results, as intervention only happens if things go wrong. Such change does not seek to deliver improvements. Bass contrasts this with the greater contribution leaders can make to transformational change, as their goal is to develop and inspire their followers, generate awareness beyond self-interest, connect to a collective sense of identity and create a greater sense of ownership (1990:23).

Kouzes & Posners' (1995) study describes observable behaviours or activities associated with transformational leaders. These include seeking opportunities for change; challenging processes; questioning the status quo; inspiring a shared vision; modelling behaviours;

sustaining commitment and enabling others through collaboration. Davidson *et al.*'s (2006) study on leadership styles in health care describes key strategies and suggests that setting collective goals, using joint decision-making and supporting others to meet these, can empower colleagues to value their role. Several NHS studies on networks advocate a mixed transactional/transformational leadership style. Goodwin *et al.* states '*professionals within networks… need charismatic leadership from one of their own*' but warns that managers need to be seen to actively engage with respected professional leaders, as alone '*managers from the 'lowerarchy' generally possess less kudos and leverage*' (2004:384). This was of significance as the study would explore the experiences of Designates when they were exposed to different styles of leadership within the Network.

2.7 NHS organisational structure and networks

The NHS's sixty-year history had seen twenty major national reports aimed at improving its organisational structure (The King's Fund 2011a), yet throughout that time hierarchical 'command and control' had dominated, with a brief unsuccessful attempt at consensus management[22]. The concept of competition introduced with the internal market in the late 1990s, continued with engagement from clinical managers as in Lord Darzi's reforms (DoH 2008). The 2010 restructure altered the operational framework and strengthened the clinical voice, while maintaining control by management teams (Appendix 2).

2.7.1 Networks

The majority of studies looking at health service networks were American or Australian and investigated networks for their cost efficiencies in the management of patients' care or

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[22] Management teams where each officer has the power of veto, sometimes disparagingly called 'lowest common denominator decisions'.

patient outcomes. Studies examined how services were integrated into network structures and found hierarchical management was the most common in contract-based ‘vertical’ informal networks (Suter *et al.* 2009). One article examined the administrative challenges of ‘child welfare’ through a centrally managed referral pathway model (Embry *et al.* 2000). While none met the required focus, their review was beneficial for wider knowledge.

NHS Scotland’s research of the late 1990s, dominates the British literature, their definition of a network will be used in this study:

> ‘*Linked groups of health professionals…working in a co-ordinated manner, unconstrained by existing professional and [organisational] boundaries to ensure the equitable provision of high quality and clinically effective services*’ (Scottish Executive & DoH 1999, para 3).

NHS Scotland’s Health plan (2000) gave governmental support to the development of networks, which were centrally funded for period of one to two years. Networks were recognised as contributing to improved quality, flexibility and workforce benefits including support and contact between scarce practitioners. Network principles were of:

- Clarity of management and clinical leadership
- Defined multi-disciplinary/professional operational structures
- Clear guidelines and investment in professionals’ education and training
- Consistent quality assurance framework across network
- Staff agreement to adhere to principles and audit work

These principles were shared by the intervention which formed this study’s focus.

The Scottish networks were centred on disease specialisms, e.g. Coronary Heart Disease, and the majority of research focussed on innovative use of resources, patient satisfaction and outcomes. Later a West of Scotland managed clinical network (MCN) was established for child protection. Research on this looked at how the MCN created joint education and guidance and acted as an overarching affiliation for agencies and NHS health boards. Other studies beneficial to review included ones which examined the staff perspective on their services, the network's principles and the problematic issue of information sharing.

More recently several Scottish MCNs have been studied retrospectively: Guthrie *et al*. (2010) traced MCNs' mandated origins, development and the impact of devolution to the Scottish Executive. The study updated findings and examined new areas such as succession planning and collegiality's limits. While the study agreed with other research regarding benefits for patients, it also found that networks enhance professionals' understanding of specialist work, and that staff felt better able to respond to change and develop innovative solutions. They stated that the network's context influenced how staff worked together and '*clinicians and managers of existing organisations grew resistant to MCN "core team" undertaking interventions…in what they understood to be their responsibilities'* (*ibid*:198). The study found that though leadership was aimed to enhance collaborative principles, professionals failed to acknowledge the complexity of team creation and sustainability, a finding also seen in a study on health and social care teams' integration where tensions occurred as practitioners struggled to work as a team (Glasby & Dickinson 2014).

English networks developed from the Patient's Charter's (DoH 1991b; 2000a) promise of a 'seamless service', and were re-emphasised in Your Guide to the NHS (DoH 2001). Thomas *et al*. (2001) studied management across research networks, both from outside and within, and suggested that leadership styles included ‘bottom up’, ‘top down’ or ‘whole system’, and while each was favoured by different groups, no one style suited all networks. Harvey *et al*. (2000) researched five networks and noted that they all chose different leadership styles depending on their focus. While the narratives of these studies described behaviours ascribed to transformational leaders such as collaborative, creative and innovative, the studies had not specifically reported on the leader’s behaviours. This BMJ editorial appears to welcome networks for their inclusiveness:

> ‘*A real attraction of networks is that they focus on clinical issues and create organic and flexible organisations that can respond well to a changing environment. This and their collaborative nature seem to appeal to many clinicians*’ (Edwards 2002:63).

The NHS SDO commissioned Goodwin *et al*. (2004) to undertake a systematic literature review across public and private sector networks to examine managerial effectiveness. The findings held key implications for network governance and leadership structure and policy, as seen in the NHS SDO (2004) briefing paper’s typology of network structures:

Network Structure	**Characteristics**	**Advantages and disadvantages**
‘Enclave’	‘A flat structure with no central authority based… on shared commitment... Successful in enabling information and ideas to be shared by professionals with a common interest’	‘Appropriate where voluntary participation, high commitment and internal equality of status are required… [example] initial creation of clinical professional networks’
‘Hierarchical’	‘Have an organisational core and authority to the work of members… Successful in… predefined tasks and complex divisions of labour’	Appropriate for ‘controlled integration of a well-defined set of services is necessary… poor in gaining support… [from] professionals if it restricts their freedom’

'Individualistic'	'Loose association of affiliates… based on… negotiation of contracts… responsive to change'	'less good at integrating care… better at supporting creativity and motivation via incentives'

Figure 1: Typology of networks (NHS Service Delivery and Organisation R&D programme 2004:3-6)

Goodwin *et al.* indicated that the managerial style most likely to be successful across types was central control, though this could be problematic for 'enclave' structures as it was '*unlikely to be acceptable*' as '*autonomy and clinical freedoms are essential*' (2004:6). They noted a 'boundary spanner' – someone who helped overcome issues of interagency fragmentation – was an important role. The research found successful networks had clarity of task and purpose, defined boundaries and technological solutions to facilitate outcomes and information flows, and, importantly, networks required an inclusive approach. The study found transformational leadership behaviours '*most neatly map*' onto more '*social integrated groups*' (*ibid*:61) or those which arose from enclaves. And that professional leaders with transformational behaviours were needed to steer a network vision, though large size and bureaucratic practices stifled innovation. They noted that public sector networks were '*affected by societal values, egalitarianism and the "public sector ethos", factors which may suggest the greater importance of solidarity and trust*' (*ibid*:309).

A study by the National Institute for Health Research (NIHR) Service Delivery programme looked at paediatric networks including the authority held by health representatives at the Local Safeguarding Children Board (Currie *et al*. 2010). They found '*effective leadership'* was seen '*as a panacea to improve'* public services' performance (*ibid*:13) and that policy-makers favoured transformational leadership as a way to deliver substantial change. But they noted that '*demands of policy-driven patterns of accountability'* alongside the dominant technical/professional bureaucracies being '*non-receptive to transformation by others'* may mean that '*distributing a transformational variant of leadership may prove normative, rather than empirically evidenced'* (*ibid*:14). The study also noted that professional hierarchies limit collaboration, and that participants were likely to orientate more towards their employing organisation's interest and accountability structure than to the network. The study found that transformational leadership behaviours linked to and '*buttressed*' professional influence (*ibid*:156).

Another NIHR study used interviews at eight large health networks, triangulated with policy and reviewed literature, to focus on '*how health care services could be organised through hierarchies, markets or networks'* (Ferlie *et al*. 2010:12). The study examined six criteria: stakeholders, formalisation, context, resources, origins, and shared processes to create a typology. They found that resources and shared information systems had only moderate benefits; that higher learning and performance was confined to network subsets; and that the demands of management and 'power imbalance' could overwhelm the benefits of clinical leaders. They suggested there should be a '*shift from line managerial role power and bureaucratic style of management to a broader emphasis on leadership'* (2010:150) and that transformative leadership should be delivered within a 'small team' approach.

Sheaff *et al*.'s (2011) study of effectiveness in seven clinical networks found, as did Thomas *et al*. (2001), that the 'bottom-up or top-down' way in which networks were formed affected their performance. Though there was no explicit commentary regarding leadership styles, Sheaff *et al.* found that while networks often start 'bottom-up', managers would seek to control them and with an altered dynamic the networks became more susceptible to disruption from changes in the wider NHS. They noted that individuals benefitted from network participation and '*the main incentives to cooperate were the expectation of practical help-in-kind'* (2011:207). Sheaff *et al.* (2012) later used case studies to research GP partnerships and non-hierarchical organisations, and found the main issues were the identification of the partnerships' goals, governance, management, and patient satisfaction and outcomes. They noted that the structures though predominantly democratic exerted control through '*peer pressure to prevent shirking'* (*ibid*:15).

2.8 Supervision and joint reflection groups

Literature on clinical supervision in nursing has built up from its origins in psychotherapy and Peplau's work on experiential learning (1957). Early research on clinical supervision developed in psychiatric nursing and health visiting, possibly as a way to assure clinical competence in the absence of physical clinical skills. Two early studies looked at the benefit of supervision in child protection work. Drews' study highlighted the need for supportive supervision to ensure practitioners could '*overcome the conflict'* inherent in their role's dual aspects of authority and help (1980:247). Anderson noted that nurses' therapeutic relationship with abusive parents needed '*quality supervision…[to] facilitate the nurse's effectiveness*' (1980:33). Both studies remain relevant to today's nurses and my study.

By the 1990s, clinical supervision was recognised as a mainstay of nursing practice, though with studies focusing on whether its aim should be managerial, educative or supportive, much of its literature reflected the debate around nursing professionalisation. Rolfe saw supervision managerially as a '*special learning situation in which the supervisor-student relationship is employed as a tool'* (Rolfe 1990:195), while Butterworth & Faugier (1992) widened this notion and linked the concepts of supervision with mentorship, theorising that supervision's reflective dialogue had grown from experienced colleagues overseeing student's technical skills. They suggested that the United Kingdom Central Council's (UKCC)[23] requirement for nurses '*to maintain and develop standards of practice'* (1992:6) combined with supervision as articulated in the Department of Health (DH) 1993 policy:

> *'a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence…and should be seen as a means of encouraging self-assessment and analytical and reflective skills.' (1993:9)*

A later UKCC document endorses the managerial aspect of clinical supervision as a way of skilled supervisors working with practitioners '*to reflect on practice… identify solutions to problems, [and] improve practice*' (1996:3). Supervision literature reflected nursing practice's increase in accountability and autonomy (Spence *et al.* 2001; Hyrkas *et al.* 2003). Clinical supervision became more important managerially and educationally and in an effort to demystify and clarify clinical supervision's expectations and processes, the Royal College of Nursing issued a 'how-to' guide (RCN 1999).

Butterworth *et al.* (2008) reviewed clinical supervision research and found most contained four broad categories: practitioner engagement; supervision's usefulness as an educational and supportive device; ethical debate and challenges; and its effects on staffing and patient outcome. They noted that engagement varied from 18% of practice nurses to 85% of mental health nurses; they also found that the training methods for staff in supervision changed over time (*ibid*:266). They stated that supervision's educational and supportive

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[23] Professional body responsible for the live register of nurses

nature was reported most frequently: ‘*nurses who have experienced clinical supervision suggest that some of the most important advantages are restorative*’ (*ibid*:267).

The restorative benefits of supervision were noted to have occurred in several dimensions, including practitioners gaining increased confidence (Marrow *et al.* 2002; Zorga 2002). In addition, studies found, supervision helped nurses gain a deeper awareness of their ways of thinking, decision-making and performance (Spence *et al.* 2002; Crisp & Green Lister 2004). Studies have also found there is a decreased sense of professional isolation (Bedward & Daniels 2005; Jones 2001) which was linked, by Rowse’s (2009) UK study of children’s nurses undertaking child protection work, to nurses’ feelings of fear and vulnerability. Bradbury-Jones’ (2013) study with eight nurses examined supervision as a counterbalance to the emotional toll of child protection work. The study used reflective diaries to facilitate nurses’ subjective self-examination; their accounts were then used to help them articulate their responses when in supervision with another. The study found there was an increased self-awareness and enhanced learning. A different perspective on supervision was offered by Landmark *et al.* who found that supervisors ‘*benefit from providing clinical supervision, suggesting that it improves their own practice as it encouraged them to ensure they were up-to-date with the latest practices and techniques*’ (2003:837).

Butterworth *et al.* established that only a minority of nurses felt that supervision was not necessary or beneficial, and noted research about the function of clinical supervision being to create a workforce which was aware of ethical dilemmas. They noted that ‘*reflection …enables a set of ‘morally superior values*’ to be adopted. They leave open the question of whether caring professions should act as '*judges of normality'* or exercise their influence to control what they deem risky behaviours (2008:268). This may be in conflict with how nurses work in the child protection arena, where finely balanced judgements must be made as to what constitutes normal and acceptable adult behaviour in a child's life. Butterworth *et al.* also found improved patient outcomes were reported; they explained this may have been due to nurses' increased knowledge, satisfaction and ability to understand the nature of caring. Overall they suggest there is little evidence that clinical supervision is negative.

The mode of clinical supervision's delivery can be either one-to-one or groups, where colleagues act to supervise each other or an identified supervisor is used. The specialism of the practitioner and the aim of supervision appears to influence the mode of delivery with one-to-one tending to have a hierarchical or case-management focus and group tending towards the emotional well-being and educational needs of the supervisee being the focus. Group supervision's more open inclusive approach has similarities with action learning sets, in that nurses facilitate their own learning by joint reflection. These reflective groups operate in the belief that group processes and dynamics are more powerful in generating understanding and insights into complex issues through sharing, support, challenge and feedback (Pedlar *et al.* 2005). Platzer *et al.'*s study of nurses and midwives found that their previous experience of learning and current work-culture imposes barriers to group learning. These included an individual's commitment or resistance to shared learning and group members' interactions, '*in particular their willingness to expose themselves to the judgement of others*' (2000:1001). Likewise, Carver *et al.'s* (2014) study of student nurses found supervisees' fear of being judged only lessened with understanding of their role and group dynamics. While group supervision would appear to have many commonalities with a network mode of working, none of the reviewed studies on networks reported on clinical supervision as a concept, despite describing the negative effects of hierarchical supervision (Embry 2009; Sheaff *et al.* 2012).

A systematic literature review of group supervision by Francke & Graaff warned that, '*although there are rather a lot of indications that group supervision of nurses is effective, evidence on the effects is still scarce*' (2012:1165). This echoed Buus & Gonge's (2009) review which concluded that in psychiatric nursing, while clinical supervision was perceived as a good thing, only limited empirical evidence to support that claim could be found. Francke & Graaff's review indicated that group supervision produced '*Positive effects … regarding idea support, trust, risk-taking'* (2012:1176) and that topics included nurses' own job satisfaction, autonomy, personal growth and improved emotional responses. This mirrored Butterworth *et al.*'s (1999) study's findings which had focussed on how nurses reacted to changes in their work and team building, and had described group supervision as having decreased nurses' exhaustion. In Berg & Hallberg's (2000) study of group supervision in psychiatric nurses, they found that individuals who valued each other more became friendlier and more supportive. They stated confirmation was an important reciprocal aspect of group supervision and described this as an awareness of self during dialogue with others, which encouraged a willingness to change and improve practice. While the transformative aspects of group supervision were documented within these studies, links to the idea of gaining or monitoring practitioner competence are not made clear.

The concept of competence as the measure of adequacy in safeguarding practice is stipulated in statutory guidance for safeguarding children (RCPCH 2014). This requires that medical staff undertake regular reviews of practice by either clinical supervision or peer review. For doctors, clinical supervision involves direction of practice, whereas peer review is defined as: '*person(s) of the same ability or expertise providing an impartial evaluation of the work of others and involves a group of peers discussing and providing opinions which the individual can accept or reject'* (RCPCH 2012). A study by Thomas & Mott traces the requirement back to the GMC's response to the Cleveland enquiry and the court's interest that paediatricians giving evidence are '*peer reviewed'* (2013:60). This demand focussed doctors' understanding of the need for and limits of joint reflection. Thomas & Mott suggest that while peer review or action learning offers an informed platform for beneficial individual reflection, individuals must take ownership of their own decisions.

2.9 Conclusion

The specific research question had no comparative literature base and this lack of research focussed on Designated professionals had been noted previously in studies which had taken topics aligned to the Designate professionals' remit as their focus. These included Peckover *et al*.'s (2015) study of Designated and Named professionals' experiences of undertaking Serious Case Reviews, and Appleton's (2012) examination of how primary care organisations managed and delivered their safeguarding responsibilities. The lack of research does not have a single cause, but may result from factors including the small number of professionals who undertake the role. The absence of a child protection career structure for either doctors or nurses affects the number of trainees, who often undertake research as part of their assessment process.

To balance the lack of specific research, a diverse literature on contextual aspects of the study has been reviewed. A historiographic method has been employed to attempt an understanding of how society has and continues to define childhood. Child deaths or events which were linked to the development of policy and legislation are delineated chronologically and the contemporary views of influential professionals are considered. The use of journalistic templates – employed to harness the 'zeitgeist' of earlier events and construct a repeating narrative frame in which the state and its workers are ascribed the status of perpetrators – and the effects on certain individuals has been examined.

Management theories were examined including works on change management and leadership style such as hierarchical and transformational. Particular attention was paid to British literature on healthcare networks and their findings on leadership, structure and benefits. These provided a framework from which to understand and analyse the patterns of behaviour and concepts expressed by participants in the data. The research on networks included ideas expressed in O'Toole (1997) and Fahey *et al*. (2003) and studies undertaken in different circumstances and settings provided examples of corresponding findings and acted as an exposition of the theories. Prior research offered a degree of validation for the inferences drawn from this study's findings and helped to indicate the biases and weaknesses in this research.

The study’s methodological choice of participatory action research did not rely on prior research; this guards against derivatively following or being influenced by past studies. However this was not absolutely achievable due to an academic literature review exercise necessary to establish the originality of this study, the researcher’s embeddedness in the area of the NHS under examination, and the researcher’s employment responsibility to be well informed about the subject. The next chapter will look at the local context for the study and the methodology chosen for the research.

CHAPTER THREE: METHODOLOGY AND THE STUDY'S CONTEXT

3.1 Introduction

The previous chapter reviewed the literature applicable to the study's focus and its wider context. The Network innovation aimed to address the shortages in capacity within specialist practitioners at a time of higher demands and an external assessment of 'poor' performance. It also sought to resolve pan-county issues by the implementation of agreed improvements across five neighbouring Primary Care Trusts (PCTs). However, the simultaneous occurrence of the unexpected National Health Service (NHS) changes altered the situation, expectations and demands on the Designates' role. I was mindful of these broader contextual influences when I retrospectively reviewed the documentation for phase one and as I explore with the Designates their experiences in phase two interviews. There were other opportunities to hear the Designates' experiences, concerns and stressors when they came together at the Network's forum meetings, and, with consent, some of these accounts formed data for the study, along with my own reflective diary.

This chapter sets out the methodological choices taken and considers both my Designated nurse and researcher roles working in the particular circumstances from which the intervention and research questions arose. As Stringer (2007) suggests, a descriptive 'snapshot' which details the relevant geography, demographics, history and politics can enhance action research's context-bound findings. The rationale for the study's sampling, recruitment and interview methods, and the processes used to gather, analyse and interpret the data alongside the ethical issues and implications for practice are discussed. While the originality of the study lies in the transformation of the Designates’ role, the atypical circumstances and the specificity of these particular conditions limit generalisability.

3.1.1 Local context

The local circumstances were an important factor in the intervention’s conception and later continued to influence its operation and sustainability. Child protection had a high profile nationally and locally with the county receiving a second ‘inadequate’ judgement from Ofsted in 2010, the consequence of which was fortnightly monitoring of its ‘improvement plan’ by the Department of Education (DE) and Care Quality Commission (CQC). Health commissioners were required to make advancements to training, communication, consistency of information, and improve looked-after children services and GPs’ engagement. The CQC also recommended the Designates’ powers should be strengthened and that there should be further recruitment. The literature review detailed the NHS White Paper’s reform agenda (Department of Health (DH) 2010), and the consternation caused by the uncertainty of the post-reform architecture and accompanying media debate. The wider circumstances appeared to add urgency and heighten the PCTs’ interest in securing a resilient safeguarding model in health.

3.1.2 The local NHS setting

The County had been divided into five PCTs, which later became seven Clinical Commissioning Groups (CCGs); these covered three local authority (LA) areas (see Figure 2).

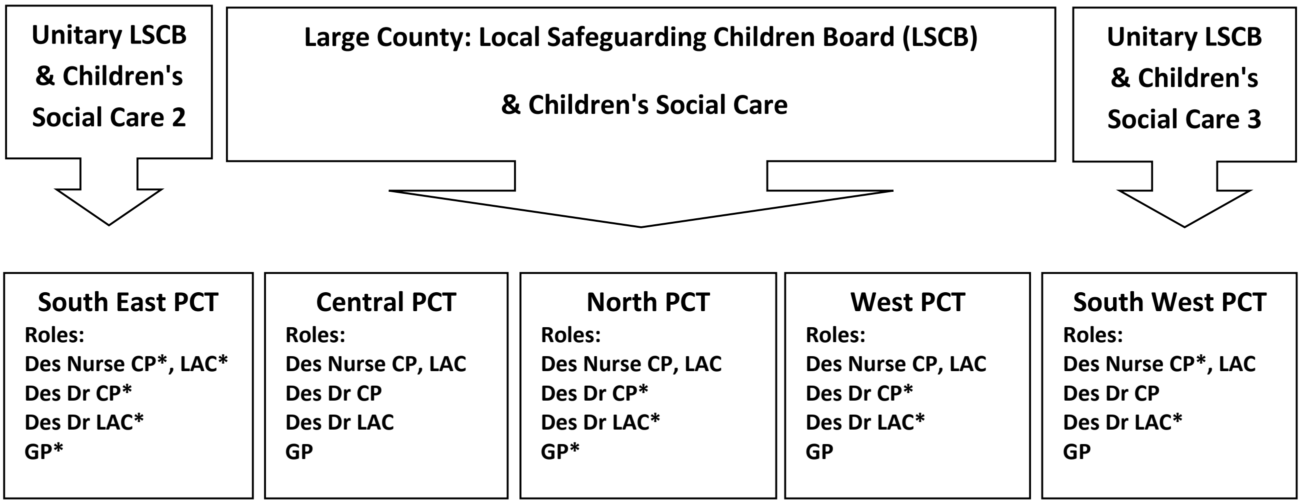


Figure 2: Organisational chart and the Network's established staff posts

*Designate (Des); Child protection (CP); Looked-after children (LAC); General Practitioner (GP); Vacant post indicated by **

In preparation for the decommissioning of PCTs, and to ensure continuity of service during the concomitant staff reductions, an interim measure known as 'clusters' was introduced whereby management structures, personnel and resources were shared. In the transition year, August 2011-August 2012, the three northern PCTs/CCGs kept their original boundaries and formed the North cluster, while the South cluster was formed by the two southern PCTs/four CCGs (Figure 3). At this time, twelve of the fifteen Designates in post worked in the northern PCTs, with all the longstanding Designate vacancies being in the southern PCTs. In phase two of the study the former cluster partners perpetuated North and South identities by continuing to share systems: this was at variance with the whole-county identity fundamental to the Network approach.

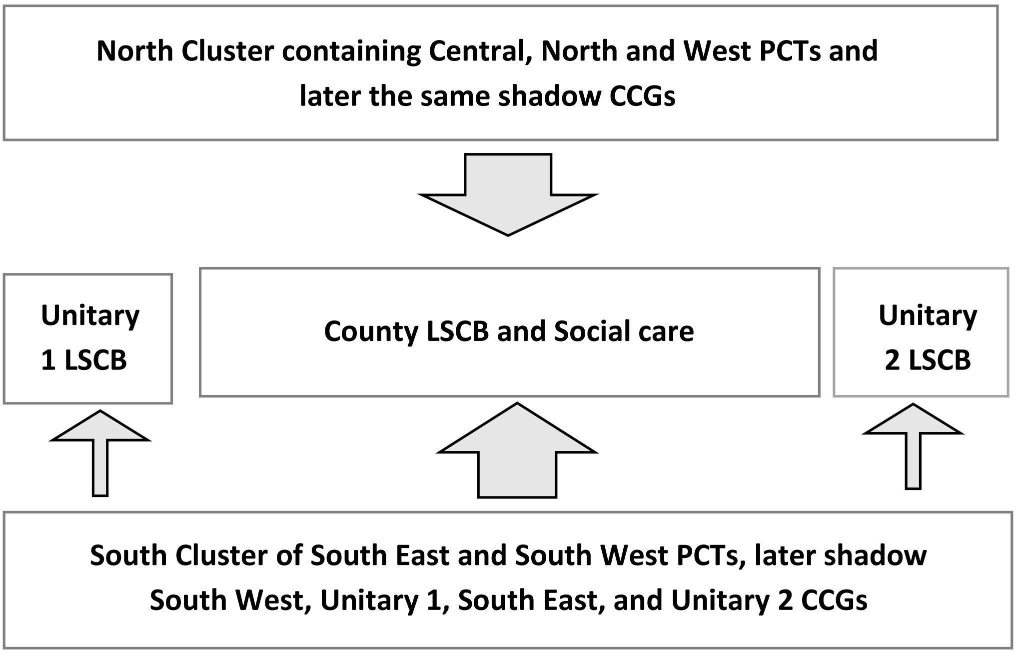


Figure 3: Organisation and Cluster configuration from August 2011 to April 2013

3.2 The intervention: Working together

3.2.1 The process of change

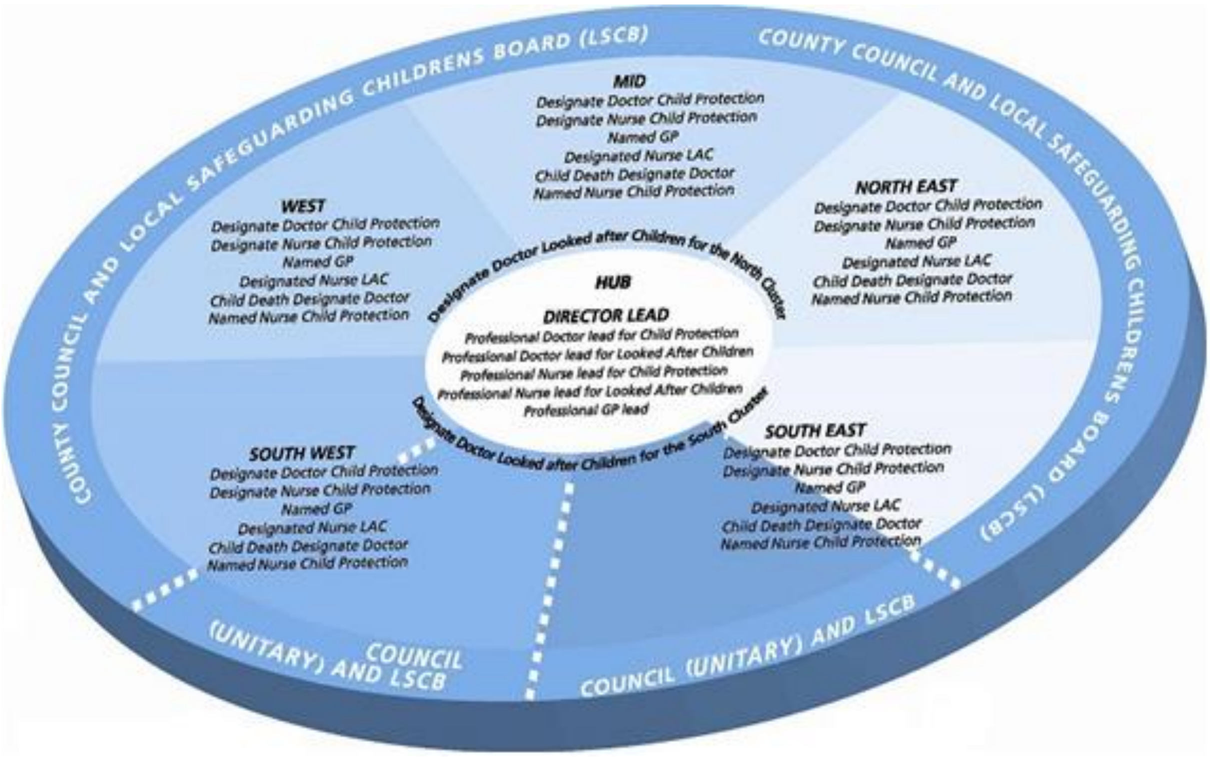
As a locality Designated nurse I suggested that we might address the requirements of the improvement plan by exploring alternatives to the customary way of delivering the Designated functions. This was a period of change in the NHS and a time when the PCTs were alert to the CQC's criticism of inconsistency and lack of vision in safeguarding, and these circumstances appeared to have provided an opportunity to innovate.

The five PCTs supported the development of solutions in a series of facilitated meetings for all the Designates broadly based on the principles of change management. The five months in which the three meetings were held would usually be seen an extremely short timeframe for a managed change process. But, as circumstances made it difficult to retain previous working practices, the question for the Designates became what the change would look like.

3.2.2 The Network solution

Prior to the change there had been no official mandate to share responsibilities across PCT areas. This meant all work needed to be instigated, developed and implemented individually by each PCT, leading to disparities within practice and making partnerships with other agencies complicated. The Network model required PCTs/CCGs to indemnify their Designates to work outside their boundaries. It ensured Designates retained the primary responsibility for their own area, while allowing them to cross PCT borders and act as a team to give clinical advice and cover the workload of the vacant posts. The model also required each Designate to hold the delegated 'lead responsibility' for a common high-demand issue, the objective being to stop duplication, free capacity, increase Designate availability, narrow variation, and share scarce resources. Figure 4's infographic is used to illustrate how the CCG areas within the network model related to each other.

The PCTs were the first to create the additional role of Named nurse within commissioning to work alongside the Designated professionals and increased the overall number of posts. Professional lead roles were introduced to work in the Network's Hub with the remit to: provide clinical leadership across diverse interests of the PCTs; coordinate and drive forward clinical developments; and improve partnerships with outside agencies. Governance for the model was via a Network Board which comprised Directors from each PCT/CCG.



*LSCB: Local Safeguarding Children Boards [24]

Figure 4: Illustrates the virtual borderless nature of the Network

3.2.3 Meetings as action forums

The Network held business meetings to address operational matters, raise awareness of developments, and improve cross-area communications. The Network also held professional ‘forums’ to provide a safe space where Designates reflected on and discussed their work, which could act to validate their views and advance knowledge (Koch & Kralik 2006). Practice issues were raised and agreement sought on which concerns to prioritise with the consequences discussed at the next forum. The format of these meetings aligned with the action research methodology, and the review and revision of the Network’s operating framework occurred there. As the Designates supported the study, with their agreement I gathered content from some forums for use in phase two of my research study.

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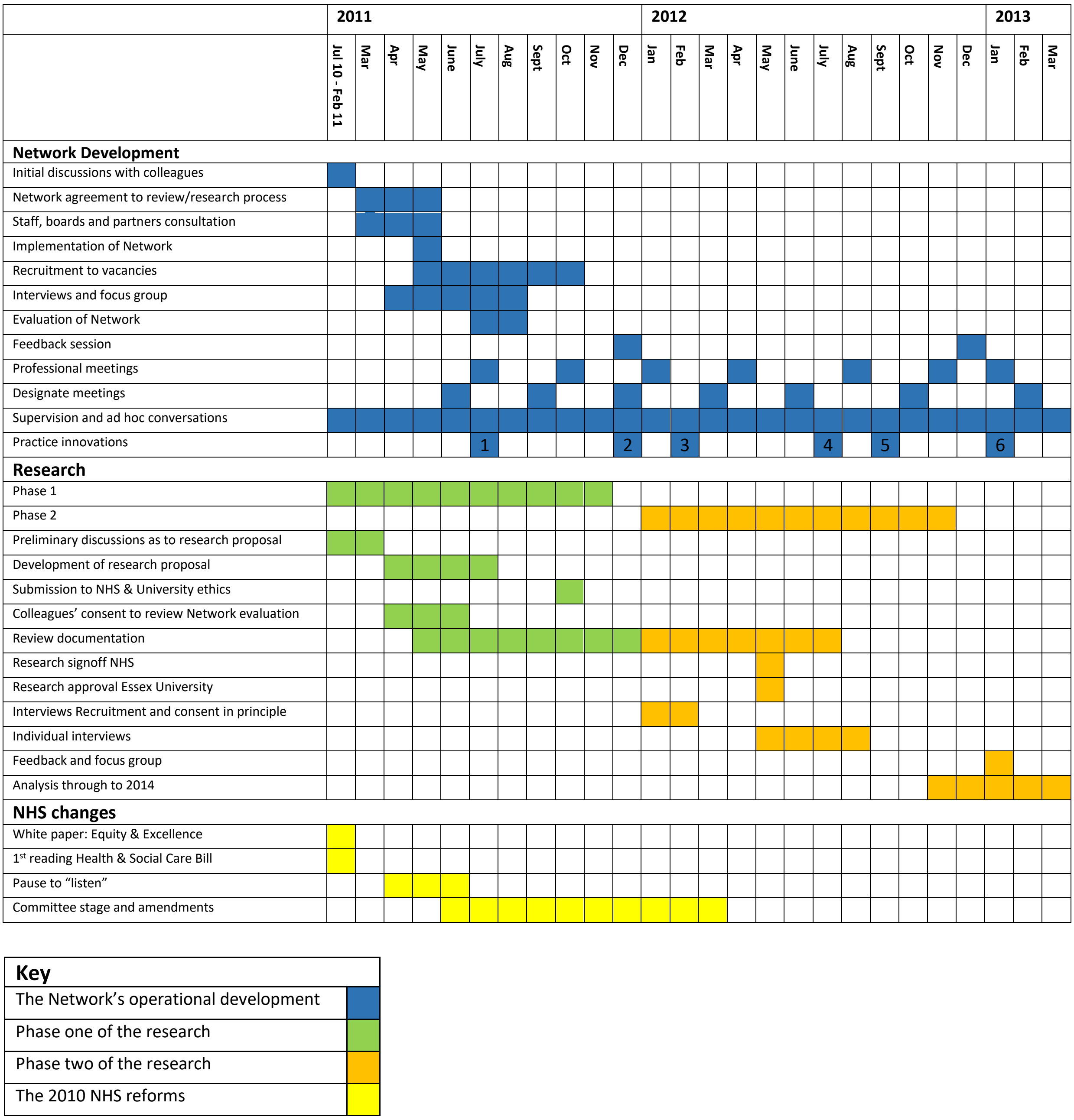
[24] LSCB have a range of roles and statutory functions and are established via the Statutory Instrument 90: 2006.

On a few occasions I would be explicit in foregoing my facilitative professional lead role to act as a passive listener. However this was difficult to maintain, as participants still sought to engage me in the discussions. While this might be proof that my presence as a researcher caused little disturbance to the group dynamic, it might also indicate I was not achieving sufficient distance from colleagues to allow me to make independent sense of what I heard. In the main most of the hard data gathered from the forums was retrieved retrospectively from minutes, while my reflective diary was helpful in considering my place in the discussions and my reactions to colleagues for indications that I had inadvertently reshaped their narrative. The only discernible difference between when I was present at forums and when I was not, were the topics, rather than the expressions of ideas; when the lead doctor facilitated, the discussions seemed to focus more on medical practice areas.

3.3 The Research

In choosing a methodology several factors guided the choice including the question itself: the study's context; the characteristics of the intervention; my interpretive conceptual framework and understanding of knowledge acquisition; and the study's commissioner and audience (Oliver 1997). This study had twin aims: to be of use for the Designated professionals; and to form part of my professional doctorate with the appropriate academic standards and rigour.



	2011											2012												2013		
	Jul 10 - Feb 11	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Network Development																										
Initial discussions with colleagues	🟦																									
Network agreement to review/research process		🟦	🟦	🟦																						
Staff, boards and partners consultation		🟦	🟦	🟦																						
Implementation of Network				🟦																						
Recruitment to vacancies				🟦	🟦	🟦	🟦	🟦	🟦																	
Interviews and focus group			🟦	🟦	🟦	🟦	🟦																			
Evaluation of Network						🟦	🟦																			
Feedback session											🟦												🟦			
Professional meetings						🟦			🟦			🟦			🟦				🟦			🟦		🟦		
Designate meetings					🟦			🟦			🟦			🟦			🟦				🟦				🟦	
Supervision and ad hoc conversations	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦
Practice innovations						🟦 1					🟦 2		🟦 3					🟦 4		🟦 5				🟦 6		
Research																										
Phase 1	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩																
Phase 2												🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧				
Preliminary discussions as to research proposal	🟩	🟩																								
Development of research proposal			🟩	🟩	🟩	🟩																				
Submission to NHS & University ethics									🟩																	
Colleagues' consent to review Network evaluation			🟩	🟩	🟩																					
Review documentation				🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟧	🟧	🟧	🟧	🟧	🟧	🟧								
Research signoff NHS																🟧										
Research approval Essex University																🟧										
Interviews Recruitment and consent in principle												🟧	🟧													
Individual interviews																🟧	🟧	🟧	🟧							
Feedback and focus group																								🟧		
Analysis through to 2014																						🟧	🟧	🟧	🟧	🟧
NHS changes																										
White paper: Equity & Excellence	🟨																									
1st reading Health & Social Care Bill	🟨																									
Pause to "listen"			🟨	🟨	🟨																					
Committee stage and amendments					🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨												

Key	
The Network's operational development	🟦
Phase one of the research	🟩
Phase two of the research	🟧
The 2010 NHS reforms	🟨

Figure 5: Network development, research progress and NHS changes timelines

3.3.1 My role as a participant researcher

I was cognisant from the beginning of the study that the relative positions of myself as practitioner/researcher and my colleagues as participants would exert a certain amount of influence on the research. At the beginning of the change I was, like my colleagues, a locality Designate: though I was also the instigator of the original review into our working model, this may well have had an influence on the dynamic of my relationship with colleagues. Being mindful that there would be a complex and ever-changing interplay of relationships and expectations was in itself a way of keeping possible negative and positive impacts on the study under review. My understandings acknowledge both the concept of reflexivity and the notions that *'power is everywhere… because it comes from everywhere'* (Foucault 1990:93): to this purpose I put in place strategies aimed at countering harmful effects. Ramazanoglu & Holland's (2002) work offered a way to think about the features of power, its identification and effects in relationships; the conceptualisation of power, hidden and explicit; ethical judgements which limit and frame the research; and accountability of knowledge, how and what stories are told. Critical reflection was supported by this layered approach and was captured in my diary and memos. These acted as a way of '*exploring often messy and confused events and focusing on the thoughts and emotions that accompany them'* (Boud 2002:10). The discipline of reflection enabled me to be both alert to the possibilities of situations and to take amelioratory actions.

In the pre-network phase, I had been in-post as a locality Designate Nurse for many years, as had several other colleagues in the county. This meant we shared the same socio-historical work context and were bound by our wish to continue in safeguarding children practice. These commonalities ensured we spoke the same 'language' and were able to understand and recognise nuances and situational references within each other's accounts. Being an 'insider' was beneficial especially when analysing documents in phase one, however I did not accept the data at face value, as I used memos throughout the analysis to temper my initial response. I would reflect on the context of the statement and on why they had expressed the sentiment the way they had, an example of a memo being: *'they state their lack of influence is a problem, but some do not accept that their professional status alone is no longer enough'*(July 2012).

From a more personal stance I reflected that given my longevity in post, colleagues might have *'expected me to be stuck in my ways and less willing to accept the change'* (January 2011). However some appeared to look at my enthusiasm and be persuaded by it, I diarised '**** said to me "people do not usually change", so is it just my support of this [model] that is lessening their anxiety?*' (March 2011). In a later discussion with my practice supervisor I reflected on the inadvertent power of leadership and considered if colleagues could be influenced by my enthusiasm into accepting a change they might not otherwise have done. I noted '*certainty in the face of uncertainty can be very persuasive*' (March 2011). This prompted in me more passive interactions with others during the developmental phase.

At the launch of the Network and before my academic research began I became one of the four professional leads: part of our role was to present a single Network view by collecting and coordinating the Designates opinions. Though that function was conspicuous before my study's data collection, I reflected that my role's modelling of researcher characteristics (Minkler 2005) may have blurred the boundary between Network duties and my research. This included, in line with a goal of PAR, Network meeting discussions which were aimed at developing the roles of the Designates (Chataway 1995; Reason 1993). I diarised in June 2012: *'Colleagues are asking to participate in my research as they feel that knowledge* *sharing has been successful and research would benefit our future role’*. This insight provoked extra diligence in explaining the separateness of my academic study verbally at Network meetings and on the participant information sheets (Appendix 3). It may have been that colleagues’ psychological investment in the production of knowledge equalised any perceived power dynamic and prompted their feelings of shared ownership in my research.

My insider position had allowed me to build a professional rapport with colleagues focussed on our similarities such as our shared background or people we knew. While analogous histories were beneficial, my embeddedness limited attempts to be a neutral observer, and I determinedly tried to acknowledge my biases. Our rapport enabled reflexive comments, as was exemplified in a colleague’s remark: *‘“do we have to wait for your Sun exclusive [thesis] to identify which of the unequal equals is not doing any work, or are you addressing that in your day job?*”’ I wrote ‘*that’s telling me then!!’* I interpreted this as pointing out which aspect of researcher/participant they felt had primacy and where my accountability lay. Though being 'inside' made interactions complex, one benefit appeared to have been their willingness to express sentiments they might not have felt appropriate ‘outside’. A diary entry appears to indicate Designates were concerned their knowledge would be judged: *‘the Network appears to have developed a closed, self-righting mechanism whereby people only expose lack of knowledge to those they feel have more expertise*' (June 2012). I reflected that the Network’s exclusive membership had produced a covert power-base, an ‘elite’ of which my role as lead and researcher was part, where access to knowledge and power favoured only those ‘inside’.

The NHS's history of hierarchical and professional 'command and control' structures made the possibility of power imbalances a concern. To equalise power, I designed strategies aimed at ensuring participants' views were present within the research, including seeking their permission for the research to happen, inviting all to participate, and allowing participants to decide the venue and time of their interview. Colleagues also had contact details for my University supervisor and line manager if they wished to discuss the research. Participants had the power to withdraw from the study and to withhold consent for the use of materials they jointly created at meetings and, importantly, their feedback became crucial data.

Reflexivity was aided by my reflective diary which held written, *post-hoc* accounts of situations or feelings. The aim was not just to capture the details of time or place, but to clarify thoughts and feeling, alongside any lack of comprehension or insights I had (Garrity 2013). The diary provided a distance from which to reassess, and by interrogation I was able to make explicit causes and effects at play within encounters. This indicated why a way of thinking might have been unhelpful and facilitated the development of different approaches for future use (Tanner 2006). Billings & Kowalski suggested that reflection helps to develop the *'intellectual and affective dimensions of clinical practice'* (2006:104) and its importance is now recognised as part of NMC revalidation (2016). Reflection was used throughout the research process to self-scrutinise, providing insight and feedback which were effective in directing my thinking to different perspectives.

3.4 Participatory Action Research

Kurt Lewin's early work first defined action research as: '*A type of... comparative research on the conditions and effects of various forms of social action*' (Lewin 1948:202-3), and suggested directly applying the findings of the research to the focus of the research (Hart & Bond 1998). As action research (AR) requires collaboration to achieve negotiated change, Stringer (2007) noted that all action research was participatory. Participatory action research's (PAR) non-reliance on a pre-established body of work was seen as beneficial when working with others who are directly affected by the issue, as it allowed the study's focus to actively respond to the situation (Huxham 2003), and so achieve knowledge and change (Reason 2004). PAR's history of use in health services research (Koshy *et al*. 2011) may be related to its goal to '*democratise the knowledge creation process… and emphasise the importance of collective action*' (Stoecker 1999:28). PAR can be useful in situations where those affected by the research are also fundamental to its outcome (Koch & Kralik 2006) or where the purpose of 'action' is educative (Carr & Kemmis 1986).

Stringer observes PAR '*commences with an interest in the issues of a group… its purpose is to assist people in extending their understanding… and thus resolv[e] issues'* (2007:27). The process encouraged participants within the working environment to raise concerns and allowed knowledge acquired through the research to contribute directly by cooperative endeavour to the understanding or resolution of issues by gaining support for co-constructed solutions. The principle of discovery and examination of issues was in line with the study's aim. PAR's characteristic cyclical progression facilitates reflection on actions which serves to validate earlier conclusions and allows data generated to be checked with participants. The Network's pattern of meetings/forums harmonised with the cyclical nature of PAR allowing its benefits to be gained without adding further time commitments. This simple sequence – plan, action, evaluation, amend plan – shares its emphasis on learning by experience, which has resonance with the 'learning cycle' work of Argyris & Schön (1978).

3.5 Design

The research design was consistent with general qualitative methodologies, with PAR able to adapt to changing circumstances and, as the intervention and study progressed, to '*take advantage of serendipity*' (Neuman 2006:34). As PAR methodology specifies no time parameters it allowed the study to incorporate data from a two-year period covering the Network's developmental and operational phases. PAR does not require minimum amounts of data to grant a study legitimacy, though 'data saturation' is seen as important to securing research quality (Bowen 2008). In one way the study's own limits, such as the time frame, circumstances and homogeneity of the Designates, acted to control variables and ensure saturation, but its uniqueness also meant that no amount of data would make the study replicable (O'Reilly & Parker 2012). Inclusion of data from different sources was seen as supportive to the notion of saturation, and phase one saw a variety of written documentation used, together with feedback on findings from participants. Data collection in phase two was open-ended and consisted of volunteer interviews, discussions at meetings, and my reflections and observations (Bekhet & Zauszniewski 2012). This continued until such time as I felt that new information produced little or no change to the codes (Cresswell 1995)

PAR assumptions concerning the collection, analysis and interpretation of data accepts that knowledge is filtered through and controlled by socially constructed language and shared meaning. This interpretative approach recognised the interrelated nature of participant and researcher; the common sense approach to the shared small world complexity (Denzin & Lincoln 2003) of safeguarding in the NHS; and the situational constraints of the study. Purposive sampling correlated well with the study's aims as it drew on 'rich cases' from the small sample frames which were able to generate data filled with depth of meaning (Patton 1990). Data was returned to in an iterative process to seek clarification of ideas, categories and codes (Guest *et al*. 2006), in an endeavour to provide meaning which 'fitted' the situation and could be validated by the practitioners.

3.6 Participants

Inclusiveness was important in the Network's development and for PAR, and to this end all clinicians were informed and invited to participate in the study with Participant Information leaflets being made available which described the project. As there were only a small number of possible participants, the study was open to all those who had been in post for more than one year between 2010 and 2012. The self-selecting participants were drawn from the child protection and looked-after children Designated doctors, Designated nurses and Named GPs. All had experience, prior to taking up their Designate role, of between one to twenty years in various medical or nursing fields. Both the study and the Network had fewer males than females and the age profile ranged from thirty-five to sixty-two years. During phase one of the study there were twenty-eight Designated posts: thirteen were vacant and eleven staff participated in the research. At the time of the 2012 data collection, there were thirty-seven Designated posts: seven were vacant and twelve Designates participated, eight having done so previously. All the Designated nurses took part, but fewer than half of the doctors did. Only four of the new members were included, the others not meeting the study’s criteria of being in post a year.

3.7 The Research Process

3.7.1 Phase One: Development of the initiatives

The study’s premise – to chart longitudinally the effects of the intervention – required collection of data at several points. The first phase happened at the time of the network model’s development, which began with informal discussions and progressed via a consultation and a managed change process. To secure strategic commitment from the PCTs which would enable the Network to operate, simultaneous progression was required on two different work strands. One thread was aimed at PCT Boards, to support negotiations on how to overcome the operational difficulties of devolving authority and control over financial resources, and included Human Resources processes necessary when adjusting employment. The other strand and the study’s focus were the discussions with colleagues from neighbouring PCTs.

The majority of the Designates’ discussions on how to transform the service and address concerns took place during the change process. The initial meeting brought together the county’s Designates for the first time, some of whom had never met before. The first two consultations were ‘open forums’ and were led by a PCT Director who I supported from a Designated nurse perspective. Colleagues were asked to consider a nascent network model and express their opinions on its drawbacks, potentially deliverable benefits and whether there were alternatives to the structure. Comments were displayed on a flipchart to allow the group to reflect. Practitioners were asked to contribute any follow-up ideas, their comments being amalgamated and circulated; this allowed the group to review the idea. This feedback loop seemed to allay any initial reluctance, aid their understanding of the model, address their concerns and misgivings, and acted as a check for accuracy and authenticity. Practitioners supported the principle of ongoing ‘review and revision’ and wished it to be fundamental to the Network. This extended to support for my research’s focus of an exploration of the model.

The unexpected delay in receiving approval for this research from the NHS and University influenced the study’s design for data collection. After receiving ethics approval and the consent of the individuals concerned, I was able to retrospectively access the original discussions and, together with the business case, minutes, observations, and my reflective diary they form the historical data used in the first phase of the study. Any commentary recorded from non-consenting colleagues was excluded.

3.7.2 Phase Two: After the first year

The second phase interviews took place between twelve and fifteen months after the Network’s launch (Figure 5). The intervening months had seen three development days, led by the manager, for all in the Network to examine aspects of practice or any shortcomings they saw for the Network. These were also aimed at helping to build group cohesion and consolidate working customs in an effort to establish group norms.

The individual fifty-minute audio-taped interviews were conducted at a place and time of the participants' choosing. To ensure full informed consent, interviews began by revisiting the Participant Information leaflet, which set out how the data would be transcribed, used, stored and destroyed in accordance with the Data Protection Act (UK Parliament 1998) and Caldicott principles (DH 1999b). It was restated that participation was voluntary and that they could withdraw at any time without prejudice. Importantly, to differentiate between my roles of professional lead and researcher, agreement was sought that if practice concerns were raised in the interview, it would remain their responsibility to voice those again outside the interview. However any concern of professional misconduct could be raised externally by either party. In the semi-structured (Appendix 5) interviews I sought to identify the participants' individual 'rationality', and only if clarification was required were supplementary questions asked.

The Network had been functioning for nineteen months when the second phase findings were formally fed back, first to the participants and, when validated and approved, to all in the Network. This audio-recorded focus group documented the group's reactions to the findings and was incorporated into phase two analysis.

3.7.3 Supplementary data sources

PAR methodology supports the collection of data across time, settings and participants. This allowed the interviews to be supplemented by focus specific data created at meetings including the development days and other alternative sources (Koshy *et al*. 2011; Stringer 2007). Forum meetings were intended as a space where together colleagues could reflect on practice issues and concerns, as a way to understand their experiences and discern the implications for practice. A considerable amount of the practice changes seen in the action research project arose from these meetings. The collaborative and self-managing nature of the group discussions appeared to facilitate people giving voice to their opinions or views. These provided additional data which added depth to the research and helped identify the relevance of the key themes. As not all practitioners consented at each meeting, only selected materials were accessed for the study. My reflective journal also served as an aide-mémoire and has been used in the analysis and interpretation: as Kemmis *et al*. note, journals can be a way for the researchers to verify rigour in qualitative inquiry (2014).

3.7.4 Analysis: Ideas and concepts

A key step in analysis was the organisation of the various data sources to aid information retrieval. This supported the complicated process of distillation from large quantities of data the '*significant features and elements that are embedded in [it]. The end result… a set of concepts and ideas*' (Stringer 2007:8). Beginning during data collection, materials were repeatedly examined to identify the manifest and latent content within them, and from these to draw a loose framework of patterns and categories (Joffe 2012). Ideas were taken apart by asking a succession of questions such as 'what was going on?' and 'how did people acquire the knowledge they needed?' (McNiff & Whitehead 2006:40). The data was then reassembled to establish if patterns were discernible and meanings were assigned to concepts, and discrete ideas, once developed, were tested by comparison to the actual words used (Miles & Huberman 1994).

While PAR analysis has no prescribed steps, I followed thematic analysis principles as a *‘useful tool to illuminate the process of social construction*’ (Joffe 2012:212) and to enable a range of data to be incorporated to help trace how a particular representation developed. Once concepts were identified, materials were re-read several more times to review and locate the incidents where the idea/concept were expressed. This technique was undertaken as Ryan & Russell Bernard suggest that *‘themes are only visible (and thus discoverable) through the manifestation of expressions in data’* (2003:86).

3.7.5 Analysis: Coding and themes

Across data sources, concepts with similar characteristics formed groups and during the process of comparison these changed, grew larger, split into new ideas, were subsumed or excluded. A matrix was used to examine ideas in a systematic and spatial way to identify links. Categories were checked for uniqueness or idiosyncratic relationships and to discern subtle similarities and differences within and between them which added richness of meaning. Ideas began to form more detailed clusters with a greater depth of meaning. These sometimes linked to ideas from elsewhere, including the literature. In phase one, hardcopy narratives and spreadsheets were used to track ideas and sources, and in phase two, the computer programme MAXQDA[25] was used.

The aim of the analysis was to establish either commonality or difference in the bulk of the data, and the cyclical process meant refining, dividing and discarding resulted in larger and more complex themes. Neuman describes such strategies as ‘*methods of agreement [and] difference*’ where narratives are ‘*similar in many respects but differ in a few crucial ways*’

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[25] MAXQDA is professional software for qualitative methods of data analysis, coding and retrieval.

(2007:473). This was useful in enabling me to pinpoint divergent features in situations sharing common factors, such as Designated doctors and nurses experiencing key issues differently.

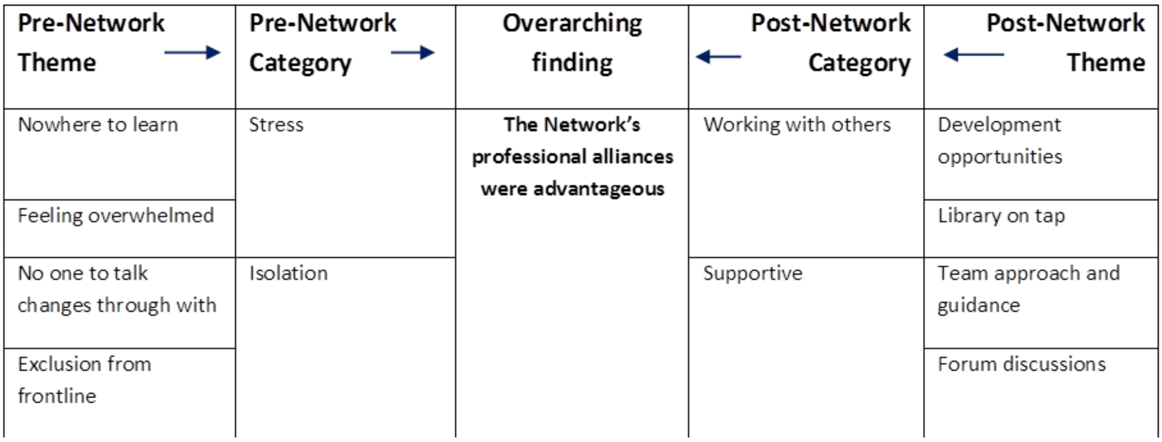
To generate a discernible theoretical model, Ryan & Russell Bernard (2003) suggest that themes should be examined to build a hierarchy of relationships. The process of coding and recoding the same materials was iterative. Leaving intervals allowed me to test my own earlier code identification. This gave me confidence in the concepts and themes noted, and reduced the risk of either missing themes or losing them by discarding data. Repetition acted as a method of triangulation and strengthened the findings particularly when alternative evidence sources were examined simultaneously. The research operated on an *'adequacy principle'*, with the review of data and context and revisiting of minor and major themes providing confidence that saturation had been reached (Guest *et al.* 2006). The *'hard work of analysis'*, performing *'two simultaneous activities: Mechanical data reduction and analytic categorisation of data*' (Neuman 2007:460), took time, particularly in phase one. The computer programme used to examine phase two data initially created many codes, but the ease of data manipulation and retrieval helped create a hierarchy from which to compare themes. Examples of the initial codes from both phases, the frameworks of themes and categories from both phases, and an extract from the interpretation matrix are shown in Appendices 8, 9, 10, 11 and 12.

3.7.6 Interpretative strategies

The process of the categorisation of concepts and themes supported the interpretation or '*sense-making'* (Wolcott 2009:30). Wolcott described the process as including the '*intuition, past experience, emotions, [and] personal attributions' (ibid)* of the researcher and suggested that conclusions could be *'argued endlessly but neither proved nor disproved to the satisfaction of all*' (*ibid*). My sense-making entailed the construction of a 'framework' (Appendix 9) with dimensions determined from my understandings including reflective memos written during analysis. This '*framework of assumptions and concepts'* (Neuman 2007:469) acted as a prism through which to scrutinise the data for fit or anomalies.

The research's provisional findings were fed back to participants to ensure that I had not misrepresented their experiences and to establish if there were new connections to be made. A review of the data with the participants allowed it to be *'reanalysed, reassessed and assembled into a final package'* (White *et al*. 2009:287) and, if the interpretation was validated, it would strengthen the framework and nascent 'argument'.

The themes and categories from the separate phases, while similar, did contain differences, which illustrated how the changes in their working lives had altered the Designated professionals' experience. To visualise these chronologically the twin perspectives were charted in association with each other. This allowed the links between them to emerge, and while they did not unify, the themes did converge on specific points of interpretation. The diagram below shows this process for one finding and is an example selected from the final matrix which is included in Chapter Six.



Pre-Network Theme →	Pre-Network Category →	Overarching finding	← Post-Network Category	← Post-Network Theme
Nowhere to learn	Stress	**The Network's professional alliances were advantageous**	Working with others	Development opportunities
Feeling overwhelmed				Library on tap
No one to talk changes through with	Isolation		Supportive	Team approach and guidance
Exclusion from frontline				Forum discussions

Figure 6: Extract from the chart illustrating how themes and categories from both phases' data converged into a single overarching finding

3.8 Ethical considerations

The ethical approval process provided independent scrutiny of the research methodology and ensured the study's compliance with the appropriate standards to safeguard participants' interests. Approval was sought from the University and the NHS (see Appendices 6 & 7), though changes in the NHS's research application process (DH 2005 & 2012) delayed the final approval, which was granted from the local NHS Research Department.

The study used Beauchamp & Childress's (2001) four key principles as a framework to guide the research. Also, as a nurse, I adhered to the Nursing & Midwifery Council (NMC) 'Code for nurses and midwives' (2015). The Code is compatible with Beauchamp's principles, as it requires that nurses act in people's best interest, communicate effectively to gain fully informed consent, protect people from harm, uphold confidentiality, respect their privacy and right to exercise preferences including withdrawing from research.

3.8.1 Respect for autonomy

From the beginning the PCTs and my Network colleagues were aware and supportive of the research's aim of developing knowledge in practice. Cognisant of my lead role, it was made explicit before recruitment began that there was no expectation of participation nor were there any sanctions for not taking part or for withdrawal. A Participation Information leaflet containing full details of the study was available to all, with an invitation for those interested in taking part to contact me. I recognised '*Informed consent is at the heart of ethical research*' (DH 2005:2.2.3), and only valid when participants are fully informed of risks and benefits. Informed consent is also not absolute (Beauchamp & Childress 2001). To use the historical documentation, retrospective consent was sought from participants, and consent to use minutes from phase two meetings was sought contemporaneously. All preferences were enacted and the contributions of those who had declined consent were deleted from the data.

3.8.2 Nonmaleficence

All practitioners taking part in the study were experienced doctors or nurses working in safeguarding children: they were accustomed to discussing highly sensitive and complex subjects, and familiar with the notion that the objectives of 'doing no harm' and upholding confidentiality can collide. The potential for these principles to conflict was present in this study, as 'open' questions provided an opportunity for participants to disclose poor decision-making. To prevent this dilemma, the interviews began with the explanation that although confidentiality was an aim, if concerns for their practice arose, this would be brought to their attention and a discussion continued outside of the study. Whilst this is recognised as contentious in research environments, carrying as it does implicit messages on trust and power, it did not appear to prompt concern in the experienced professionals who were familiar with this as being the premise of relationships they had with colleagues.

The research required that no participant details were recorded. To assist anonymity their locations' identities were obscured and certain points are reported in a more generalised way. For retrieval purposes interviewees were assigned a code, e.g. (X25), which have occasionally been withheld if inclusion would have pinpointed the participant's post. However due to the singular nature of this study and the small number of participants, absolute identity protection could not be guaranteed as practitioners might be able to deduce others' identities. These concerns, and the issues which might arise if anonymised quotations were used in publications, were discussed with participants and their consent was gained. Data collected for this research were stored non-identifiably in a secure environment and will be destroyed on doctoral completion.

3.8.3 Beneficence: Sharing knowledge

Collaborative enquiry aimed to democratise knowledge by facilitating individuals' deeper understanding, though it is the participants' choice as to whether they draw benefits from the joint examination of shared concerns and co-devised solutions (Beauchamp & Childress 2001). The thesis element of the research, which concerned their experience, has been shared with local colleagues, and may also benefit the wider safeguarding community by its addition to the small pool of research.

3.8.4 Justice: Fairness

Research guidance acknowledges that while research may involve an element of risk, *'the risks must be in proportion to the potential benefit*' (DoH 2005:2.2.8), and Fowler (1989) suggested that nurses have a duty to ensure the advancement of their profession by increasing research-based knowledge. Both statements, while containing the concept of justice or fairness (Beauchamp & Childress 2001), acknowledge the limits of research in health. Resources used to undertake the research were part of the Network development plan and were seen as fair, as the research had the potential to benefit all by improving the Network. The study's collaborative character, and the open nature of the review, ensured that all participants and supporting health organisations had fair and equal access to any derived learning and innovative practice developments.

3.9 Critique of methodology

The literature search elicited little research which shared the exact focus of the study. The search strategies endeavoured to overcome the inherent publication bias by widening then narrowing search terms, and using publishers' websites, though this produced mostly tangential materials. The academic process entailed a wider review of the concepts around children, child protection and policy development, and meant the researcher entered the study with a degree of prior knowledge. The use of a PAR methodology (Koch & Kralik 2006) for analysis and discovery and the lack of applicable research literature freed me to discover the method, including its pitfalls, for myself. The study had joint aims: to provide feedback and knowledge to colleagues on which they could act to improve practice, and to complete the research as a solitary academic endeavour.

PAR has been criticised for its lack of precise process and adherence to prescribed steps, though this ignores PAR's basic premise of flexible, collaborative enquiry which requires mediating mechanisms to represent the engaged stakeholders (Stringer 2007). PAR methodology utilised my dual involvement and allowed a connection with data and actions to be maintained (Kolb *et al*. 2011). Colleagues had become familiar with an inclusive PAR methodology during the change process and the collaborative approach had given rise to shared values. PAR encourages creativity with an aim of practical relevance to those involved, with the need to achieve practical solutions predominantly taking resource and time precedence over the academic research.

Discussions about methodology with colleagues influenced my choice of action research; all were supportive and some colleagues even volunteered before the formal request for participation was made. While the closeness of my 'insider' position offered benefits, I was aware of the challenges that the dual roles of participant and researcher could present. Kemmis *et al*. (2014) recognised that PAR methodology contains several problematic issues which include power imbalances, the insider/outsider factor and the choice of the research topic. Given that I had been employed in the locality as a Designated nurse for many years before the study began, it is arguable that if I had tried to extract myself to get an 'outside' view it would have falsely affected the data. As the Network launched my role became one of four who facilitated opportunities for collaboration in an endeavour to equalise any perceived power imbalance and ensure colleagues' views were heard and a consensus achieved on which actions to prioritise. My researcher role was a solitary pursuit which while tacitly acknowledged and supported by colleague had not been meant to influence the collaborative action research working of Network, the outcomes of which in the main are not represented in this study. Strategies were in place and a reflective diary was used to keep me aware of the potential of any conflicts or imbalances occurring and, during analysis, memos were used to a similar effect.

The methodology relied on data gained from documentation, a procedure which has a history of use in organisation research (Symon & Cassel 2012). Phase one findings stem from the managed change meetings' materials, which the group had reviewed and corrected. Also include as data was the group's feedback on my phase one finding. The interview data in phase two acted to verify and legitimise the findings, as the same themes observed in phase one were identified in the interviews (Cresswell 2007).

The practical and interventionist approach dominant in child protection literature is recognised in the paradigm of childhood; this made social constructionism familiar to Designates and allowed them to examine the emerging concepts and findings to create knowledge (Ritchie & Lewis 2009). As PAR draw on social constructivism, reflections on the consequences of actions within the Network's forum discussions become data to be analysed in an iterative process. While it is accepted that if another researcher had undertaken the study the resultant data and outcomes would have differed according to their different focus and actions, this does not invalidate the findings of this study, which stand alone as a slice through time in the Designates' experiences. PAR practice requires that assumptions are checked, and this was undertaken through discussions at the forum meetings, where colleagues' responses became part of my interpretative conclusions.

3.10 Conclusion

This chapter has critically explored the complex arrangements and local context of the Safeguarding services which prevailed at the time. It gave a brief overview of and debated the Network's structure and staffing level and, with the aid of diagrams, explained their contextual relationships. The chapter discussed the qualitative methodological choices and steps taken for the research design, data collection, analysis and interpretation. By making explicit the steps and reasoning behind these processes, I endeavour to counter the criticism ranged against qualitative research by some theorists that it is loose (Denzin & Lincoln 2003). My personal reflections are contained in the exploration of concerns; the highlighting of motivations, interpretative paradigm and the influence of social constructionism; and in the discussion of ethical issues. The aim of making my assumptions and perspective overt and my thinking transparent is to ensure that the researcher's influence has been controlled and accounted for, and to allow the reader to understand the reasoning behind my conclusions.

It is hoped that the insights gained from this discussion will be pertinent in the following chapter which discusses the analysis of data collected during the pre-Network phase.

CHAPTER FOUR: DEVELOPING THE NETWORK THOUGHTS AND CONCERNS OF THE DESIGNATES

4.1 Introduction

The review in chapter two discussed the available literature, which focussed on the Designates' remit and the policy context for safeguarding children services, alongside research on networks and organisational change. In chapter three I examined the local and national context and demonstrated the suitability of the methodological choices and research design. Chapter four will use documents to retrospectively trace how the Designates shaped the structure and operating framework of the network idea through informal consultations and a managed process of change.

4.2 Organisational drivers for change

Ofsted's (2009) joint inspection had found the county's services 'inadequate', and its joint improvement plan had created a local imperative to secure improvements across the partner agencies. The Care Quality Commission (CQC) recommendations for the Primary Care Trusts (PCTs) required the development of a clear strategic vision and increased capacity in safeguarding. CQC wished to see a consistent approach to safeguarding support and advice, improved monitoring and quality assurance methods, and changes in response to serious case review (SCR) findings. These recommendations required the five PCT commissioners to coordinate their strategic vision and bolster services. This resonated with partners as they had long been concerned about how unobtainable one way forward was made by the need to negotiate change across five separate organisations.

4.3 Designates and frontline practice

Designated professionals' responsibilities had developed since their inception, but their expertise in the identification, diagnosis and planning for children in need of protection remained. Designated doctors worked as Consultant paediatricians to gain medical expertise in child abuse. This differed for Designated nurses, whose responsibility was for expert input into child protection and complex cases across a PCT's total child population. The 2010 reforms and 'Working Together' (DCSF 2010), while expecting practice expertise to remain, fundamentally altered the Designates' place in the system, redefining their role as strategic with the responsibility to influence commissioning and monitor local practice.

4.4 Managed change and idea development

The county's improvement plan required changes to be made. I suggested a network approach wherein PCTs worked together at both strategic and operational level appeared to offer a solution to many of the CQC concerns. This approach needed to be progressed via twin strands of work: one to build the strategic commitment and logistics to enable PCTs to combine their safeguarding services, and a second, which was the study's focus, to support the Designates to develop a collaborative working.

The latter was progressed via a PCT Director-led series of meetings which all interested parties were requested to attend, as the importance of engaging those affected by change was recognised (Koch & Kralik 2006). The aim at the first meeting was to build connections and facilitate discussion. I presented my idea of a network, and in groups Designates were asked to think about other solutions or approaches to joint working and to air concerns.

The second meeting's purpose was to gather ideas on how to address the safeguarding priorities and achieve consistency across the county. In groups, they were asked to draw what benefits a team approach could bring.

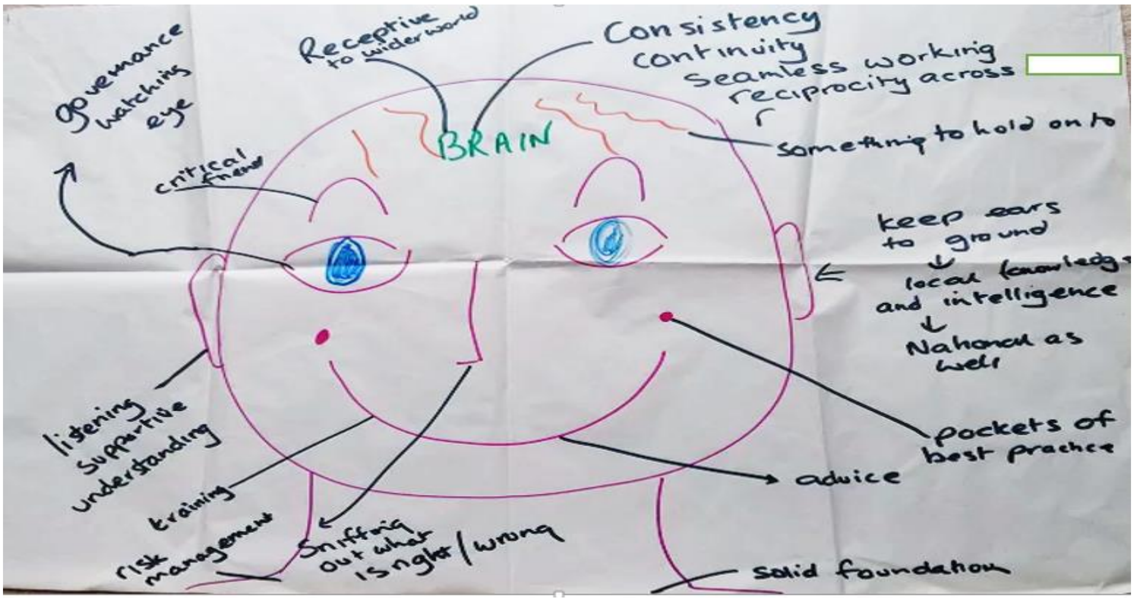


Figure 7: Example of one group's ideas from the second meeting.

All were invited to the formal third meeting: the group received a progress report on the organisational and financial strand of the initiative. Having agreed upon a refined network model, the PCT Director asked the attendees to identify service gaps or barriers to implementation and to create solutions to these issues and agree next steps. All invitees were kept informed by circulated minutes, locality discussions and briefings, and, with a small group of practitioners, I planned the launch of the model called the Network.

The data was collected from the consultation meetings, and practitioners' submissions and notes of conversations, but there were no formal interviews. For the purposes of the study the documentation was accessed and analysed post-event.

4.5 Findings from before the Network

The data was read many times to establish a ‘unique beginner’ concept (Russell Bernard 2000). The Designates’ overwhelming feelings of anxiety and confusion caused by the changes to their role was identified as the main territory for the study’s focus. This was used to group findings under broad themes containing ideas and concepts which had occurred either at different times or with separate individuals. The themes’ characteristics were often described by the Designates using a shorthand of ‘*already-agreed-upon professional understandings*’ (Ryan & Russell Bernard 2003:86) which illustrated the Designates main drivers for change. The themes identified were:

- Their relationship with frontline practice
- Their role in the commissioning of safeguarding
- The expansion in their role
- Their hopes for a different service model

Designates often employed similar words or phrases to express their ideas, though when reviewed in their specific context subtle differences would emerge. One such concept was their work relationship with others.

4.5.1 Designates’ frontline relationship

‘*Things started working differently when split with providers’*(X25)

Designates reported their previous open access to and successful collaborative approach with frontline practice had been curtailed. They found this problematic, as historically frontline practice had provided them with their source of expertise. They reported a ‘wariness’ in providers: *‘Crossing provider boundaries is difficult’*(X65). Designate nurses stated their relationship with providers had deteriorated: ‘*They think we are spies’*(X*), though they also acknowledged that their role changing to a commissioning/monitoring focus might justifiably make providers more circumspect. They recognised that in commercialised competitive markets, a CCG judgement of inadequacy could potentially affect a provider’s future contracts and cause reputational damage.

Designate nurses suggested that since the new statutory guidance (Department of Children Schools and Families (DCSF) 2010) had strengthened the Named nurses’ role, providers had become more distanced. Designated nurses reported that the guidance obfuscated the situation: ‘*Responsibilities not succinct or clear causing friction with providers’* (X65) and ‘*lack of clarity actually stopped issues being brought to the notice of the designate’* (X46). Designates reported that Named nurses had inadvertently become ‘filters’, requiring them to formally request access to practitioners, ‘cutting them off’ and ‘starving’ them of information. They reported their worry that this would make them ‘out of touch’ or ‘not up to date’ with day-to-day problems, which would mean they were unable to represent their locality’s issues accurately. They also stated they felt this situation would leave them with ‘only’ theoretical knowledge which would devalue their ‘expert opinion’.

Designates described the NHS reforms (Department of Health (DH) 2010) as a reformulation of their position which had potential for negative consequences for practice. They described being *‘marginalised… made to feel like outsiders’* (X39). They stated this presented a barrier to their advice being able to impact client outcomes or influence the wider quality of safeguarding practice: *'Currently work does not reach the level in which changes could be made; no influence'* (X65). They expressed concern that the reforms had made the health environment 'bitty', inadvertently creating *'a double silo, within Health … then within a part of health'* (X65). They stated this complicated the system, blurred ownership and made it difficult to understand – *'who knows who is responsible for what'* (X12) – potentially obscuring accountability and creating obstacles to partnership working.

Designates acknowledged the CQC concerns that there had been little visible incorporation of lessons from SCRs. They described it as their responsibility to bridge the theory/practice gap for practitioners: *'needs to impact on the frontline to make a difference'* (X65). However they reported this had become more difficult since the reforms, as they felt they were mistrusted and this prevented open reflection on practice failures with the providers. Designates stated that in their previous direct work with frontline staff they had been able to make small local improvements to practice, but the 'split' meant negotiating changes with managers instead, which they saw as unnecessarily hampering progress.

4.5.2 Designates and the commissioning role

'Worried about own ability to deal with the situation'(X25)

Historically the Designated roles operated as individual specialists within but separate from the main business of the PCT. However the NHS reforms meant Designates became part of, and were seen as crucial to, the shadow CCG management teams responsible for the post–inspection improvement plan. The management teams adopted a fast-paced business ethos focussed solely on obtaining, not providing, quality services.

Designates recognised well-informed commissioning could lead to better child protection services, but expressed doubts about their own abilities to commission and all reported concerns regarding their lack of ‘business skills and knowhow’. They described being frustrated by their posts’ seismic shift and deskilled by an ‘incoherent’ commissioning role. Designates described how previously they had shared a common language and perspective on practical care with the frontline staff they advised. However, as they shared no frame of reference or terminology from which to discuss practice with corporate staff in ‘contracts’ or ‘quality’, they felt disconnected: *‘Trying to get through to commissioners is very difficult; they speak a different language’* (X46). Furthermore, they recounted how being ineffective at conceptualising and advising on the impersonal, macro level of care left their knowledge and expertise unavailable to specialists in commissioning.

Designates reported feeling overwhelmed by this mismatch. All stated that their specialist abilities were practical and best used supporting ‘real cases’, with Doctors in particular stating they neither wanted nor were confident in the strategic commissioning role that had been ‘foisted upon them’. Designate nurses appeared ambivalent: while stating ‘*safeguarding needs to be in every fibre of the organisation’* (X*), they worried the PCTs did not fully grasp its breadth. They stated they were ill-equipped for the role and described as unfair that the PCT had devolved the whole safeguarding remit to them: *‘There is no one else accountable for the whole service or to take concerns to’* (X65).

Designates expressed concern about their capacity to deliver the new responsibilities, nurses stated ‘*an elite club of just you’* (X*) and *‘deficits in staffing [meant] Designated* *doctors are just not linked in'* (X*). Designates described issues as systemic, which required coordinated action across areas outside their remit: *'Most of the responsibility lies with other agencies so can't make things change'* (X65). They stated they felt a pressure to deliver which was compounded by the improvement plan's demand for immediate action on issues they did not see as addressing day-to-day practice concerns. Designated Doctors in particular expressed inspection work was 'feeding the beast' and that it took *'up time sorting the wrong priorities'* (X*).

4.5.3 Overwhelmed by their expanded responsibilities

'Never feeling I had a handle on all the job' (X46)

Designates reported that changes in the environment, level of scrutiny and lack of personnel caused them to feel overwhelmed: *'Too large a job, only one post to do it all'* (X12) and indicated this as demoralising: *'feels like there is little achieved striving on your own'* (X65). They expressed feeling isolated: *'lonely job - don't meet with others in the same field'* (X65) which may have been compounded by the emotional burden of child protection.

Designates expressed the need to be 'ahead of the curve[26]' on emerging child maltreatment topics as an inherent responsibility of their role. They noted newspaper headlines raised expectations that statutory agencies could act before enough knowledge was available, and expressed frustration that their lack of knowledge disadvantaged their PCTs: *'hard to know what to advise the Trust when these things are only just hitting the consciousness'* (X39). Designates reported their expert role was hampered by there being *'no place to learn what*

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[26] Ahead of the curve: In a position to anticipate or initiate the latest developments (OED online).

the current thinking is' (X12). Many reported there was a '*lack of training or courses for Child Protection specialists at level 4/5'* (X25), while others stated that *'development work takes so much time'* (X12).

Designates recognised that most of their knowledge had been acquired 'on the job' and stated self-directed learning or experiential knowledge was more useful than purely 'theoretical knowledge'. They expressed the worry that when '*things happen [you] never know the complete health picture but people look to you to take a lead'* (X65). They noted this was made worse as the immediacy of the pressure stopped them from considering all variables and neither was there *'enough time to follow up'* (X25) issues.

The CQC recommended prioritising services for looked-after children (LAC) but Designates recognised they had been unable to *'raise the profile of LAC'*(X65), as they were unable to undertake *'joint working'*(X39) with frontline staff. Designates expressed the worry there was a *'lack of LAC commissioning'* (X46) which had impacted interagency work: *'County work on LAC so small, doesn't impact at all'* (X65). Nurses noted there were benefits for a large county in the ability to work virtually and reported concerns in Information Technology (IT) deficits, specifically the lack of a secure virtual space from which to undertake joint work stating this was '*impacting the wider agenda*' (X65).

Designates reported that the consensus view of the five PCTs created a springboard from which negotiations on joint work and improvements could be launched. However they stated they were disincentivised by the time and effort needed and the difficulty of negotiating countywide: *‘Having five different PCTs to convince to take anything forward [means the] job is just too big’* (X46) or *‘lack of impact as always other PCTs to involve’* (X17). Designates reported feeling it would be ‘too difficult’ as *‘lots of effort being duplicated by amendments to [localise] everything, nothing gets advanced’* (X12). They reported dismay at their perceived unequal relationship with Social Care ‘partners’, describing this as ‘not being listened to’: *‘You lack impact as there are always more PCTs to have a say’* (X17). Designates stated they did not have the influence their expertise should have secured them: *‘Raising concerns with Social Care doesn't change anything’* (X65) and they worried this negatively affected professionals’ practice. The extension of the Designates’ responsibility to include General Practitioners’ (GP) competence concerned them, and they reported feeling overwhelmed by the size of the task as *‘GP training needs so much work’* (X25).

4.5.4 Hopes for the model

‘The idea seemed to fit the climate’ (X12)

There appeared to have been a tacit acceptance that given the pressures of local and national changes on the PCTs, working as a team was a logical progression: *‘It was a long overdue development’* (X16), as being a solitary practitioner had drawbacks and could *‘be too insular just within a locality’* (X46). Designates noted the implementation of reforms would be better accomplished if an agreed coordinated approach was taken: *‘Bring the five PCTs to see things one way for partners, makes Health a cohesive force for good practice… making it less complicated so more powerful’* (X12).

Many stated their extended remit took the role beyond their experience: '*Needs a team to deliver across a wide range of services'* (X46). They suggested collaboration was a positive development as the centrality of the child was a uniting feature: *'Keeping children at the centre… it is not about individuals'* (X46) and *'feel myself a team player… this job only exists for the best interests for the child'* (X12). They reported seeing an appeal in a service model where their influence extended outside their own locality and across specialisms: *'Breaking down the barriers between specialists, commissioners and practitioners working on different patches'* (X65). They expressed the hope that a network would contain *'a range of skills'* (X39) and would *'strengthen ties with the medics and GPs as it has been a lost relationship'* (X46). They reported *'a shared doctor and nurse voice is more powerful within and outside of Health*' (X12) and suggested: *'Stability and a shared identity will encourage other practitioners to make safeguarding important'* (X39).

Designates reported that sharing responsibilities would '*be more cost effective'* (X12) and *'ensure we are fit to deliver and have time'* (X17); this would improve output by providing *'more capacity as the problem is generally lack of time'* (X25). They expressed the hope that the model would be an efficient way to *'widen skill sets, extend learning opportunities'* (X39) and could offer *'a simple solution to accessing knowledge'* (X12). As sole practitioners they described the idea of *'having supervision and peer review within a community, [who] can then implement change'* (X65) as appealing and in agreement with an action research philosophy. They reported a *'shared workload [would] distribute talents'* (X25) and being a team would enable them learning from each other: '*using knowledge from wider area to look at problems differently, upskilling the role'* (X25).

The model's principle of one person taking overall responsibility for a distinct area of shared work was developed and seen as 'fair': '*Everyone gets to do high profile and backroom work'* (X46). They suggested this gave them the *'ability to keep up-to-date by having a reduced but more intensive portfolio'* (X17) and stopped duplication. They recognised this relied on *'effective verbal communications'* (X39), provided an opportunity for extended dialogues with others and ensured different perspectives were collated. It was suggested this group reflection was supportive in a *'troubled shared, troubled halved*' (X25) way.

Nurses reported 'equality' of status, trust, openness and being comfortable with each other mattered and became an important feature of the Designates' meetings. They expressed the hope the Network would *'present opportunities to change the system to a more inclusive culture based on collaboration and respect'* (X39). Though they acknowledged there *'needs to be leadership'* (X36), they described this as transformative with an open, honest and empowering style. They qualified this by adding that any advice offered needed to be *'behind the scenes'* (X12) and referred to their need to 'feel safe' from having 'weaknesses' exposure as a 'massive issue', suggesting the Network needed to '*enable people not to feel vulnerable or foolish'*(X46).

4.6 Conclusion

'Feels it addressed the enormity of the job' (X46)

The chapter used data collected from the managed change workshops and informal discussions, and despite their brevity a wealth of ideas have been elicited. The data captured the Designates' concerns and worries about their ability to discharge their role in the future and their hopes for the developing Network. Their experience was influenced by factors outside their control – such as the lack of detail on the reconfigured NHS, alterations to their relationship with providers and commissioners and the Munro review.

The findings appear to show they worried that their increased strategic focus had fundamentally altered their role at the expense of their operational expertise. Designates perceived the providers had become distanced from them, which interrupted information flows and ‘frontline’ contact, and as a consequence they expressed feeling ‘cut off’ and ‘out of touch’ with practice. They stated their ‘commissioning’ focus engendered feelings of inadequacy, highlighted by their lack of ‘business skills’, and stated there were scarce opportunities to access appropriate level training. The Designates’ views about working in the new environment appeared to show them receptive to changing. Their comments indicated that they envisaged the team would improve both their individual and collective power, influence and the ability to ‘be heard’. The transformation seemed to have been based on ideas of ‘equality’, ‘fairness’ and ‘sharing’.

CHAPTER FIVE: DESIGNATES' EXPERIENCES OF TEAM WORKING IN THE NETWORK'S FIRST YEAR

5.1 Introduction

> *"I sometimes find there is a tension between what I would do, or have done in the past, and what is expected now"* (W32).

Twelve Designated doctors and nurses participated in phase two with data collected between twelve to eighteen months after the Network's launch. The intervening months had seen the Network's staffing levels increased by ten new posts and recruitment into some of the long-term vacancies. As the Network's operational framework had anticipated, capacity had been bolstered by the Designates' new ability to share lead roles and work across organisational borders. In the intervening year Primary Care Trusts (PCTs) had handed over to Clinical Commissioning Groups (CCGs), but the National Health Service (NHS) reforms remained a topic of conversation at Network gatherings with Designates expressing worries as the uncertainty in the system continued the media debate.

The semi-structured interviews of phase two (Appendix 5) sought to explore key issues in their experiences, while being mindful of the themes, influence, barriers, decision making and benefits which emerged in phase one. Initially the language used by Designates in the interviews appeared similar to that used in phase one, however, while it retained some core concerns, on analysis the salience of their concepts had shifted. This was unexpected particularly as four interviewees had not been in post during the development stage.

This chapter presents the findings from phase two data using the themes of the Designates' key relationships, evolution of their role and strategic abilities, and their experience of the benefits and drawbacks of the Network. The themes' similarities to those in phase one allowed the chronological aspects of the Network's development to be accounted for and aided comparison across phases.

5.2 The Designates' key relationships

> *"[The NHS] seems to have lost the sense of being that wider organisation, there is no 'the whole is greater than the sum of its parts' any more"* (W732)

The backdrop to phase two was an NHS still in transition, with shadow CCGs, independent providers and Social Enterprises[27] all having been established, and the Designates' strategic and quality assurance remit emphasised by the Interim safeguarding arrangements (NHS Commissioning Board 2012).

5.2.1 Providers

> *"There is mistrust by the providers because they see it as being overly scrutinised whereas it is about trying to support them"* (W472).

Phase one identified that the Designates were concerned their previous open relationship with providers had been 'lost'. In phase two they stated this was as a consequence of constraints which refocussed their role at strategic level: *"This Commissioner/Provider split is going to prove to have been the worst thing ever… a child could lose their life"* (W272). Designates reported a clearer appreciation of the system and the need to negotiate access to information with Named nurses: *"Their 'Governance' forces me [to] go through them"* (W472), though they stated the denial of free access was not in the child's best interest: *"I do not think it is a child focus driving the decision"* (W572).

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[27] Social Enterprise: A business with primarily social objectives whose surpluses are reinvested for that purpose and not taken as profit (The King's Fund 2011).

They seemed to regretfully accept that their quality assurance role jeopardised their access to practice and information, but acknowledged that the providers operated in a competitive market: “*If competition is what is being asked for… you cannot get collaborative competition*" (W322). They described how, in the previous year, their direct influence on practice had decreased, as their relationship with providers was still one of ‘distrust’, though they canvassed for children’s safeguarding to operate collegiately: “*Designates are seen as Commissioners rather than supporters”* (W322).

The Designates used negative terms such as ‘split’, ‘denied’, ‘forced’ or ‘made to’ to conceptualise their relationship with provider organisations, particularly in relation to the process for requesting access to information. However, this was not personalised, and staff expressed that the faults lay with the abstract concepts of ‘governance’ or ‘competitive market’, rather than the Named nurses with whom they had brokered a new and different alliance. Unlike phase one, they did not characterise the relationship as being ‘difficult’, or one which made them feel an ‘outsider’. They appeared to have adapted to the ‘system’ and expressed resignation to the change with a plea of ‘we are here to help’.

5.2.2 The new challenges of CCG work

> *“I feel nervous about being a Designated within the new CCG, their knowledge base is not there, they have not got that history to understand the importance”* (W527).

In phase one, the PCTs – who were the Designates’ employers–downsized the workforce and move to ‘clusters’, then by phase two into ‘shadow CCGs’. In each successive organisation it was the Designates’ responsibility to help the ‘interim’ post-holders understand the complexities of child safeguarding and the organisations’ responsibilities for it. Designates had expressed the concern that Trusts had an unsophisticated view of safeguarding and, perhaps as a result of personnel changes, this appeared to have remained:

> *"My CCG had a lightbulb moment… despite the lightbulb, I do not think they truly know the enormity of what they have taken on"* (W412).

The CCG Boards' expected the Designates to lead and deliver the strategic safeguarding agenda and quality assurance framework, which the Designates reported feeling overwhelmed by: *"I find the job emotionally demanding… the extreme pressure of deadlines are excessive, there is just me, I have never known demands like this"* (W32). Designates were required, many for the first time, to report monthly at the CCG Board, write business cases, and quality assure providers' contract compliance. All reported this was stressful: *"I get told you have to deliver 'whatever' and be cost effective… you can never win"* (W171) and *"You have to do it now, a report to write… suddenly a deadline"* (W472).

Designates reported their lack of 'know-how' and ability to operate full-time in a corporate rather than clinical world made them ineffective. This changed gradually with exposure to the organisations' expectations, and some nurses stated that they had accrued skills from the demands of 'having to' complete tasks: *"I spent time with commissioners… I think it just brought out skills"* (W472). Unlike the views they expressed in phase one, some conveyed a level of satisfaction with their new role, and the influence they appeared to have at Board:

> *"Actually it was really good with my business case… in this new world, I wrote and presented it to Board, there were questions I couldn't answer but they agreed. I was quite proud"* (W*).

Phase two data appeared to show that Designates held conflicting views on themselves as competent strategic clinicians. While nurses still reported that being a commissioner distanced them from providers, the language they used no longer disassociated themselves from the role. Nurses did describe feeling unsupported: *"The CCG have done nothing to support me to understand my commissioner role"* (W*) and reported being overlooked for development. Nurses were offered safeguarding leadership courses, but described these as 'peripheral', and stated not having the opportunity for mainstream management training was proof that despite the CCGs' expectations of them, they had been 'side-lined' because they were clinical. Later they reported the CCG's attitude to them as clinicians with 'business' skills, had gradually helped them accept their monitoring and standard-setting role, though there was still a wariness which they reported was as a consequence of the lack of preparation and CCG support in helping them to adapt to the 'deadline' driven corporate culture.

5.3 Challenges of being an expert

> *"The challenge is… as a practitioner you take problems to someone else. Now I am that someone else"* (W732).

Designates used a confident tone when they spoke of their expert status in practical child protection casework. They described their responsibility as to know the answers in complex cases: *"We are there for the difficult stuff, so people only ring us when things are not straightforward"* (W412). They suggested it was their moral responsibility to do the 'right thing' for children but reported this sometimes came at a personal cost.

One recounted a painful episode when they risked their good relationship with a partner agency by disagreeing with its planned intervention, as they knew it was not the 'right thing' for the child: *"It comes down to the moral thing to do, who needs to win here? The child."*

(W427). Another described the recording of safeguarding assessments as a conflict of conscience. They acknowledged professional best practice demands objectivity and sticking only to the facts, but believed child protection was often subjective:

> *"Recording neglect is a worry, you write about social difficulties and implications of [parental] choice. You can be challenged, 'How do you know this will happen?'"* (W171).

They depicted their judgements as forecasts of how parental behaviour could affect the child's future. They felt that merely recording facts would obviate their expert clinical estimate of the implications for the child of unchanged parental behaviour. This suggested that to protect children the 'right thing' was to record informed subjective opinion, which is what the Designates described doing. They noted the safe space the Network's professional forum offered was an advantage, as such 'dilemmas' could be discussed and aired openly with colleagues who understood the complex decision-making process which surrounded these judgements. The ready presence of colleagues with whom to discuss such scenarios, at a time when they were most pressing, acted as group supervision and as an adjunct to formal supervision, and reinforced the value of the peer review process.

Several Designates stated that their 'nightmare' was to find themselves the subject of media coverage. They reported feeling they had *"dodged a bullet"* (W427) stating: *"Every time I hear on the radio there's been a child death… I stop 'Is that our area?' and then go 'phew' when it's not"* (W272). They described that being aware that complex cases can easily 'go wrong' had acclimatised them to the threat of media exposure, but stated the central worry that they could have 'got it wrong' drove their practice.

> *"Public opinion does play a part in how I think... If you knew and didn't give the right advice you are damned and if you didn't know, why you didn't you, and you are damned as well"* (W572).

They reported feeling that in general the threat of media interest had negative effects: "*It makes you think defensively about practice"* (W322), although some recognised a paradox, in that external scrutiny could be a positive force: *"[The media] are the ones that will really change legislation, because they push all the right buttons to make people sit up"* (W472).

5.3.1 Decision making

"The biggest risk is: have I asked enough questions to get all the information?" (W27) Designates described clinical decision-making in difficult situations as a responsibility they were comfortable with, though accepted it was stressful as they needed to 'get it right' for the child. Many found the process difficult to explain, but appeared to start with gathering 'all possible' information and then deciding a desired outcome: *"I decide where I want to be … what the final outcome is… and work backwards"* (W732). They described adding the case-specific situational information to their pre-existing framework, which was made up of national and local systems and policies, case law, their clinical knowledge and experience. From this matrix they assessed the best outcomes and tested these against discernible risks to the child, family and organisation. Dependent on the case's urgency, they assessed the consequences of doing nothing against the potential outcomes from various actions.

Designates did not describe this skill as transferrable to their commissioning decisions: "*I have found it difficult to understand what commissioning is. It is easy reading about it in a book, but it is very different in practice"* (W73). They reported feeling less able to make ‘strong and clear’ strategic decisions or cope with the consequences of failures, suggesting the pressure of these decisions caused them personal stress. They described safeguarding decisions being reliant on their ability to use accumulated clinical experience to manipulate knowledge into pattern formations from which they could forecast actions and likely outcomes, nuanced by the feedback from previous cases. Conversely, in commissioning they had no technical knowledge or experience to call upon when asked to make decisions.

5.3.2 Knowledge

> *“People listen; they take it on board. My views and expertise are now valued”* (W322).

The Designated professionals perceived they had an improved reputation as a practice-focussed ‘expert’, reporting their value was as a scarce resource of uncommon knowledge: *“As a Designate you are pretty much that one body of knowledge, no one else in the organisation can do your job”* (W392). They suggested unique knowledge gave them professional authority and regarded being ‘up to date’ and maintaining competence in safeguarding as fundamental to the knowledgeable persona they wished to project.

This came at a cost, with many Designates stating they felt overwhelmed by the amount and variety of information needed: *“I can either read about the job or do it, but I cannot do both”* (W171). Designates described being more confident in the knowledge or skills they had gained incrementally from practice: *“I feel secure in my knowledge about protecting children, because actually the judgements… I make now, are based on the judgements I made [in] practice”* (W*). This might have influenced the reticence they had for commissioning. The benefits of experience were not confined to positive outcomes: several stated getting things wrong was just as instructive: *"Sometimes you do things and think I shouldn't have… you learn by your mistakes"* (W412). Designates recounted a mix of personal, experiential and professional knowledge as crucial to their confidence and effectiveness of performance. Some noted that the breadth of their role might offer a reason why it had not been professionalised with prerequisite safeguarding qualifications:

> *"There is no formal path in terms of education… child protection and safeguarding is just so wide, it encompasses such a lot, so many different aspects to the job"* (W732).

All Designates appeared comfortable, when discussing safeguarding practice, to speak of their own expertise: *"My knowledge and expertise has a certain amount of power"* (W392). While many refrained from applying the name expert to themselves, they did speak of colleagues as experts. The nomenclature seemed to be applied intermittently: *"A key issue for me would be about being a source of expert advice, but I do not always feel that I am a source of expert advice"* (W732). This appears to simultaneously allow them to see themselves as both expert and non-expert. Quotes from the same interview illustrate this, *"I see myself, my clinical bit… as an approachable expert resource"* and *"I am quite happy to say… I am not an expert"* (W527). There appeared to be no correlation between their view of expert status, and their formal qualifications or experience. When they spoke of their role as commissioners, there was no vacillation, as all Designates reported their need for formal 'business skills' and knowledge as urgent: "*The complexities of commissioning, contract costs, key performance indicators (KPI) etc. It is a steep learning curve"* (W272). They also reported that their relatively high pay grade disadvantaged them, as they were expected not to need training or time to learn before 'delivering'.

5.4 The benefits of the Network

> *"The added value is that I sleep better knowing that I am not alone carrying all of this. I know the Network is making sure that Safeguarding is still seen as a priority… If it was not there I would have to be doing that as well as the day job, it would be my responsibility alone… Being able to tap into all those others"* (W322).

This statement illustrates the multiple levels on which the Network could be experienced. Such benefits were repeated by others and indicated that for some Designates the Network had addressed and ameliorated their earlier concerns, and that they felt supported and had peace of mind. For others the Network's shared responsibilities and influence on the safeguarding agenda had reduced their personal burden.

However the analysis also indicates aspects of earlier concerns remained, such as how they experienced their commissioning role, how they added to the Network's capacity or resources, and how they addressed cross-border improvements or combatted isolation. One overarching idea appeared to be how Designates used their influence to improve practice and this will be examined in each of the next sections.

5.4.1 Reputation and influence

> *"We are recognised as a valuable resource, that we are necessary, we have influence outside, look at what happened with the Department of Health (DH)"* (W472).

As child protection was high profile nationally and the Network was innovative practice the DH were informed of its creation. This resulted in an invitation for the Professional leads and manager to present the model to the Departments of Health and Education. The innovation was applauded and as a consequence network models were endorsed in the revised statutory guidance (DE 2013) which accompanied the NHS reforms. The influential

Royal College of Paediatrics and Child Health (RCPCH) also requested that they be "*kept posted… the RCPCH are hoping that this idea will be rolled out"* (W*). The Designates reported that this recognition gave a huge fillip to their confidence and esteem.

Prompted by DH's feedback, a commissioned external review of the Network in spring 2012 recorded that the Network was a 'valuable resource' and had benefitted the health economy and the Designates themselves. The review recorded this was noticeable externally in relationships with partner agencies who had confidence in the Network's expert opinions, and internally with safeguarding being kept as a priority on CCGs' crowded agendas. The Designates' own worries appeared to have been assuaged as they reported the Network reputation had raised their self-esteem and boosted their confidence to '*go for quality of practice instead of just what they were allowed to do*' (Reflective diary May 2012).

Several Designates commented in their interviews that the Network's external recognition and reputation had been instrumental in raising their profile. Designates suggested that the external plaudits may have increased partners' interest: *"There is a greater recognition… that we operate as a Network, partners understand our roles better"* (W472). They reported their opinion as being more persuasive: *"What you say can have a big influence"* (W395). This contrasts with phase one, where Designates viewed their influence as negligible as they were 'marginalised'. They described the Designates' enhanced profile within the Network and its reputation for joint working as beneficial, in that their voice was strengthened: *"One-person shouting 'this isn't right' is... one against the organisation; whereas being the [Network] you go along as a body"* (W412). The idea of a Designate's strengthened voice was used many times: *“Coming together has given us a stronger voice because we talk collectively”* (W472). This inverts the imagery used in phase one, when they had spoken of ‘not being listened to’ or being ‘ignored’.

Designates appeared to suggest that the Network had given them a collective legitimacy and influence they had not achieved while working in isolation. The Network had facilitated a countywide approach which allowed the Designates to develop a consensus view. This they reported as having been especially helpful to their strategic influence on looked-after children policy: *“the network has enabled us to… drive the agenda a lot faster… our expertise and views are actually now valued and listened to”* (W*).

5.4.2 Changes in practices

> *“Being a nurse in the Network is different… there is reassurance about the role, it is not done in isolation and there is cover when you are on holidays”* (W*).

Designates reported the Network’s stability and level of staff was a benefit, as it guaranteed a constancy of service by cross-cover arrangement for the CCGs, which mitigated their risks from vacant posts. Designates reported this had the added advantages of giving them ‘peace of mind’ that their area was supported and stated the incidental sharing of ideas which occurred when working in another’s locality had driven standards up. These benefits had not featured in the Designates’ experiences before the Network began.

In phase one, the nurses stated they were not in contact with the doctors. This changed in phase two as doctors and nurses worked together to deliver the service, though a philosophical division regarding the paramountcy of strategic work was reported. Nurses generally supported the strategic focus but doctors in the main did not:

> *"For Designated Doctors there has always been a tension between the operational role which gives them the clinical expertise and the strategic role"* (W*).

Some doctors were less equivocal, stating their role should focus just on 'hands-on work' work as this best protected children:

> *"We are losing sight of the important issues. So what if the KPI for X indicates this or that… Does it get those children seen and make practice safer?"* (W*)

Most, however, saw that balance between the strategic and operational focus as a dilemma:

> *"We are putting huge amounts of effort into influencing the CCGs, Directors and LSCBs*[28]*… but it is our role to be influential at ground level"* (W*).

In phase one, nurses expressed this same worry suggesting that limited contact with practitioners would reduce their influence on practice. In actuality phase two showed they successfully refocussed their influence to strategic level: *"Providers in meetings say 'what do you think?'… and they will take that on board and you can check"* (W*). The nurses suggested that their new influence had been fundamental to achieving an improved and better resourced service: *"Working through Commissioners can be very slow… but when it goes right [there are] major improvements"* (W*). This was a remarkable volte-face to the view they held before the NHS reforms or Network were implemented.

An aspect of mine and the other Professional leads' roles was to improve interdisciplinary collaboration. All Designates commented that the facilitation of joint work between Nurses, Paediatricians and Named General Practitioners (GPs)[29] had been hugely rewarding. Before

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[28] Local Safeguarding Children Boards have a range of roles and statutory functions (UK Parliament 2006).

[29] 'Working Together' guidance (DE 2013), required a specialist GP to support and advise colleagues on assessment and evaluation on child care matters, policies, procedures and research.

the Network, most of the doctors and nurses hardly knew each other and the change to a team identity was reported by all as being greatly valued and beneficial to the service:

> *"I don't think two years ago I would have envisaged working so closely with doctors because that was not my past experience"* (W*) and
> *"all getting together is a really good thing… I certainly did not know who the doctors were and now have no qualms about phoning them and asking for help"* (W*).

The NHS reforms had given the Designates responsibility for GPs' competencies, and phase one found they were very concerned about this extension in remit. In a reversal of their concerns, phase two found the nurses reported dramatic improvements in GPs' engagement. This was bolstered by the GP Professional lead developing a toolkit, which won plaudits from a national taskforce looking at training materials for GPs as 'the best they had seen' (Private communication). Designate nurses stated the Network's development of the Named GP role had improved practice by facilitating the acceptability and availability of training within the GP community: "*Named GPs' perspective has been a great boon… very helpful. We did not have that before"* (W*).

5.4.3 Leadership and the forums

My role was as one of four Professional lead posts in the Network. We were accountable and responsible to the CCGs at Board level for specialist clinical leadership and for advising how our strategic vision for safeguarding could be delivered across the CCGs. We also represented the Designates at county partnership meetings and coordinated work across the Network's virtual team. Several Designates stated the professional leads brought a more comprehensive perspective: "*You can get stuck on small issues rather than looking at the broader issues, and the professional leads have helped with that"* (W272). As noted in phase one, similar issues occurred in each of the CCG areas, which required a countywide vision and service for children who did not live their lives confined by borders.

Professional lead posts were not managerial, though the Designates held varying views on this: *"There is no hierarchy, well there is in as much as the Professional leads… but that is fine because somebody needs to carry the can or say no we are going this way"* (W392). Some reported leads should be responsible for the difficult tasks while others stated leads were valued as allies whose support and advice in difficult situations built their confidence: *"Leads have worked, because I still want someone that I can go to, to support me and be a resource… I see them as positive."* (W572). One Designate suggested that they would not admit to seeking advice from a lead, as if this were known their own authority would be undermined: *"I would just say I needed to go away and get more information"* (W572).

An aim of the professional leads was to facilitate a cohesive group by building a space where time spent with each other in discourse and debate could develop joint solutions to improve practice. In line with the action research focus, Professional forums provided that space. Designates reported the Network's agreement to discuss, prioritise and agree solutions enabled their theoretical knowledge and practice to develop. The collaboration and generosity of sharing expertise and knowledge at the forums may have been the most appreciated aspect of the Network: *"The network has given us a body of people that you know you can go to if you want some really in-depth knowledge"* (W392). Designates also reported the use of the forums by those with 'lead responsibilities' to present information for discussion and receive colleagues' feedback was a positive: *"There is that bouncing of* *information and balancing your professional knowledge with colleagues"* (W472). The professional leads' aim at forums appears to have delivered on the hope Designates expressed in phase one, that there would be reciprocity of knowledge between doctors and nurses to benefit practice. While these meetings were known as forums and not group or peer supervision sessions, the Designates reported the discussions within them could be supportive and transformative:

> *"I like the fact we have meetings… even if you have no issues, you hear the conversations… storing it up for when you do need it. The discussions drive up standards, challenge how you think"* (W322).

The CCGs and Designates had agreed shared lead responsibilities, where a Designate took the responsibility for one topic on behalf of others, as a key principle of the Network. It had been established to address the pre-Network criticism of variations in practice, and had been intended to stop duplication, offer development opportunities and support communications and shared identity. Designates were expected to prioritise this work.

However the Designates' commentary a year on held mixed views. They recognised there were advantages to one person representing the whole, as a coordinated view streamlined inter-agency cooperation: *"It makes it so much easier to have one person navigate that, before it used to be five of us all saying 'what about this or that'?"* (W*). But the majority of Designates, while happy to benefit from others' 'lead responsibilities', were reluctant to undertake one themselves. This may be due to the impact it had on their locality work: *"[It is] a bit much when you have so many demands in the patch"* (W322). Others reported their CCG required them to prioritise locality demands: "*I don't give the network its fair share of* *my time… but my patch is the priority"* (W732). Both these assertions appear to renege on earlier commitments. Designates expressed antagonism towards the idea of lead responsibilities, stating it did not make best use of capacity nor did they have control over the work. They reported this could lead to duplication: *"You go off on a tangent doing something that somebody else should be doing"* (W412). A participant, who reported feeling 'overworked', commented: *"It's sometimes harder to delegate than just do it yourself"* (W322). One concern expressed about lead responsibilities, and seen elsewhere, was they may miss important information.

5.4.4 Support

> *"Knowing there are always people around you can use as a sounding board to check out your thoughts or to ask and it is absolutely all right to do so"* (W572).

Before the Network, one concerns of Designates had been their perception of 'being the only one'. In phase two, Designates reported that because they worked with and knew colleagues, they felt supported. They suggested they felt less stressed as the Network made them feel part of a team of equals, where accessing the 'wisdom of others' was legitimised:

> *"Being part of the Network helps… if I had been sitting here alone, I might have given up and gone by now …It is simplistic, but having others who know the answers allows you to feel sure about yourself, it is a library on tap"* (W732).

Designates reported they felt the Network was a safe environment in which they were free to discuss and test ideas. They suggested the team lessened their stress as different skill levels were accommodated and reported they felt nurtured, empowered and confident:

> *"There is a very open feeling in the Network, no hierarchy… people are treated as equal, even though some obviously have far more experience than others"*(W322).

Part of their previous sense of isolation had been the lack of others with whom to discuss concerns or 'to take things to'. The professional leads fostered a sense of support where reflection on learning and practice was the focus at forums and in the doctors' and nurses' one-to-one supervisions. Designates appreciated the latter as a private 'safe space': *"I would use [Professional leads] if I was struggling with a decision"* (W572) and *"it increases your own knowledge and skills and gives you a wider outlook"* (W472). It also allowed good practice to be assured: *"I am sure now that the doctors know what they are to do and are… accountable"* (W*).

5.5 Drawbacks to the Network

The Network principle of review applied to itself, and while there was no consensus, its structure, leadership and teamwork were identified as having potential for improvement.

5.5.1 The structure

> *"It would be quite easy for there to be a North/South divide again, because the clusters led us there"* (W572).

Phase two showed the temporary measure of clusters seen in phase one continued to exert a certain pull after it had formally ceased as CCGs worked together along a North/South axis. For the locality Designates this meant their work aligned within the 'cluster' footprint and not across the whole county. Some Designates implied that a North/South focus might have offered a better model than the countywide Network. *"I don't work as well with the South as we do in the North"* (W*). Some suggested that they identified more closely with the half of the county in which they worked than with the whole Network.

5.5.2 Introduction of management

> *"A network must have a strong leadership and strong articulated direction"* (W39).

The transformational vision and collegiate style of decision-making forged by the Designates in the pre-Network period appeared to have delivered the early successes which enhanced the reputation and influence of the Network. The appointment of a Network manager, six months into its operation, was contentious and seemed to challenge the Designates who stated that they were unsure of the post's remit or value: *"In all honesty I am not 100% sure what the manager does and that is a bit unsettling"* (W272). The manager's expressed intention of transforming the Network into a self-managed Social Enterprise and establishing a hierarchical 'command and control' structure appeared to be responded to negatively by most Designates as the Network had been founded on the principle of voluntary collaboration. This shift to a transactional leadership style was a fundamental change and it became problematic for most Designates who stated their professional authority had been challenged *"our manager has made it very difficult"* (W412), and reported they felt excluded from the Network they had created.

5.5.3 Communications

"Bulletins... I think we are overwhelmed by these" (W572).

Designates indicated that certain aspects of communication within the Network were unsatisfactory. They reported feeling that they were 'missing' information, and suggested they were disadvantaged by others knowing things they did not: *"It might be that the Professional leads know this but I do not"* (W171). The study was not able to identify if this concern was linked in some way to the feelings Designates expressed at points throughout this study regarding 'not having the full picture'. As part of action research, the issue had been brought to the forum for discussion and several solutions were suggested and tried;

these included sub-groups, bulletins, briefings and a hard-copy newsletter. However, on implementation each of these proved unsuitable for some, therefore the concern remained unresolved and no sustainable solution achieved unanimous approval. A solution discussed before the creation of the Network – a secure virtual database – was unobtainable due to technological constraints.

Communication within the Network through open forum discussions, while strongly supported, was also seen by a minority as contentious. One suggested: *"You have to be careful to keep checking it out with others because everybody would have a different view… ultimately it's your decision"* (W392). One inference might be that Designates were reluctant to offer up their decisions for discussion because they did not want their opinions to be scrutinised or vetted. If the inference is correct it would contradict the principles of the Network. However, doctors' and nurses' codes of practice state that one must be accountable for one's own decisions. Inevitably, this throws up the question of how to proceed if a consensus decision is reached that one disagrees with.

5.6 Conclusion

This chapter noted that the external pressures seen in phase one had altered, a clear direction of travel for the NHS reforms had been established, CCGs were operational, the improvement plan successful, and the CQC's re-inspection praised the Network initiative.

Key findings in phase two related to the Designates' apparent adaptation to their new strategic focus and improved relationships with providers and commissioners. Although

Designates' earlier hostility to the idea of commissioning was present in their rhetoric, in practice the nurses engaged with the commissioning process. By contrast, doctors still reported that too much time was spent on 'strategic work' when their practical medical skills should be used to better effect by caring for the abused children 'in front' of them.

In phase one the Designates reported isolation and pressures of a job 'too big for one': phase two found these had been ameliorated with Designates reporting that the Network had helped to develop a reciprocally supportive team. They stated the ability to discuss concerns with others in the same role, both individually and in group or peer supervision at the forum, had lessened their stress. They noted that the interdisciplinary model had licensed co-worker status between doctors and nurses, and equality between child protection and looked-after children specialists, foregrounding their common goals and supporting team identity. Their intrinsic concerns about having enough information to make good decisions and media exposure had eased only slightly.

Designates identified drawbacks in aspects of the Network structure, management and communication. The manager's deviation from the Network's original transformational, inspiring vision and enabling, collaborative approach unsettled some Designates. The idea of lead responsibilities became contentious, and Designates drew away from shared tasks with some stating it took 'too much time'. Improvements to communications were seen as necessary, though no solution appeared to satisfy all.

The next chapter will offer an interpretation of findings and use six overarching themes to discuss the benefits and deficits of working in a reciprocally supportive environment during a period of perceived stress.

CHAPTER SIX: DISCUSSION

6.1 Introduction

This chapter offers an interpretation of the findings from the data analysed in chapters four and five, with the aim of looking across their totality to answer the research questions and, by reference to the literature, offer an understanding of the key concepts found.

6.2 Research questions

The participatory action research (PAR) methodology utilised my participant researcher role to capture the professionals' perspective from the inside. The aim of the research was to explore the experiences of Designated professionals during a time when they changed to working collaboratively. The study took into consideration whether this had altered the nature of the stresses, concerns or benefits which professionals reported they experienced. While this remained constant across the two data collection phases, the emphases of the questions differed to reflect the changes which had occurred during the intervening time.

Phase one, during development and in advance of the Network, asked the questions:

> Would team working address the challenges?
>
> What abilities and capacity did they need to address the demands?
>
> What were the Designates' wider concerns?

Phase two, twelve to eighteen months after the Network began, asked:

> Had collaboration assisted with the challenges they and their service faced?
>
> How had Network membership affected their abilities and how they worked?
>
> What new issues had impacted the professionals since the Network began operation?

6.3 Discussion format

To aid comparison across the chronology of the study, the interpretation will be presented by way of six overarching findings which crossed thematic confines. These emerged from certain dominant ideas expressed by participants which appeared throughout both data sets. The six findings each elucidate a research question from phases one and two. These will be answered in linked pairs to aid discussion across the study's timeframe, though the findings and concepts contained within them will each be discussed separately. To aid clarity the table below has drawn together the research questions from phases one and two and aligned these with the overarching findings to which they correspond:

Phase	**Question**	**Overarching finding**
One	Would team working address the challenges?	A: Designates saw the Network's professional alliances as advantageous B: Cross-county collaboration enhanced practice and encouraged new solutions
Two	Had the collaboration assisted with the challenges they and their service faced?	
One	What abilities and capacity did they need to address the demands?	C: The Network augmented knowledge, facilitated decision-making and broadened influence D: There was a need to balance resources to sustain the Network
Two	How had Network membership affected their abilities and how they worked?	
One	What were the Designates' wider concerns?	E: Changes in role expectations as perceived by the Designates F: Concomitant indirect pressures were a source of stress for the Designates
Two	What new issues had impacted the professionals since the Network began operation?	

Figure 8: Table of research questions and findings

Finding A: Designates saw the Network's professional alliances as advantageous.
Designates in neighbouring organisations had worked in isolation. The Network enabled them to form supportive social relationships which may have lessened the stress they felt when distanced from practitioners. The Network was developed to become a community where concerns were addressed via informal reciprocal supervision by co-workers.

Finding B: Cross-county collaboration enhanced practice and encouraged new solutions.
Designates welcomed the Network's leadership as it relieved the pressure on them as lone practitioners of trying to influence the health economy. It created an interdisciplinary vision to deliver improvements and undertake large-scale cross-organisational projects.

Finding C: The Network facilitated knowledge acquisition, decision-making and influence.
The Network's forum aimed to create a safe space where professionals could share knowledge and experiences. The findings indicate that the team approach acted like peer group or flat supervision to offer the ability to 'check out' advice, improve decision-making and quality assure work. The Network's external approbation appeared to act as an impetus to future collaboration.

Finding D: There was an ongoing commitment of resources to sustain the Network.
The findings show that after the initial concerns had been resolved, the Designates indicated they found the demands of the Network on them may have been unfair. Some stated the resources of time and effort that were required to sustain the Network made them question the benefits they received.

Finding E: Changes in role expectations as perceived by the Designates.

The shift in the Clinical Commissioning Groups' (CCGs) perception of the Designates' role, from a clinician to a clinical commissioner, had initially appeared to cause tension. After the NHS reforms had consolidated local power and authority in the CCGs, and the Designated nurses' position was strengthened, Designates seemed to deescalate their previous hostility and accept their corporate role.

Finding F: Concomitant indirect pressures were a source of stress for the Designates.

The backdrop of the Network innovation had been the NHS reforms, the national service review, demands from emerging child protection subjects, and changes to policy. These all appeared to increase the pressure that Designates experienced, with rapid alterations in their role and the negative coverage of child protection professionals in the media presenting reasons for their expressions of vulnerability and uncertainty in the future.

As described in chapter three, the interpretative strategy relied on a process of sense-making (Wolcott 2009), and my use of a simple matrix helped to clarify and chart the links between the codes and themes across the data sets. This is shown below:

Pre-Network Theme →	Pre-Network Category →	Overarching finding	← Post-Network Category	← Post-Network Theme
Nowhere to learn	Stress	**The Network's professional alliances were advantageous**	Working with others	Development opportunities
Feeling overwhelmed				Library on tap
No one to talk changes through with	Isolation		Supportive	Team approach and guidance
Exclusion from frontline				Forum discussions
Demand of emerging topics	Job too big for one	**Collaboration enhanced practice and encouraged new solutions**	Responsibilities shared	Working across the area
Need for expertise increased				Strong doctor/nurse relationship
Prioritisation in PCT work	Direction needed		Quality	Cross-cutting pathways
Five PCTs five directions				Leading innovation
Impacting high profile areas	Need to responding to changes in Safeguarding	**Network augmented knowledge, decision-making and influence**	Lead responsibilities	Confidence by checking
Bringing LAC to the fore				Managerial know-how
Health voice not listened to	Need to raise profile		Being influential	Being asked and listened to
Need leadership				External reputation
Voice one of many	So many meetings to attend	**The need to balance resources input to sustain the Network**	Demands of teamwork	Lack of time on patch
Double silo working				Effort of communicating
Provider split	Lack of clarity in information flows		Answerable to a Network board as well	Too many reports to write
Confused governance				Inadequate IT functionality
Loss of roles definition	What does a Designate have to do in the future	**Changes in role expectations** **as perceived by the Designates**	Increased responsibilities of the role	Performance indicators
Expansion in statutory responsibilities				Practice OR commissioning
Doctors not linked in	Marginalised		Network or cluster	Sense of ownership

Figure 9: Diagram showing the categories and themes from Phases One and Two in relation to the overarching findings

6.3.1 Finding A: Advantages of professional alliances

The process of change and developing ownership

As Pettigrew *et al.* (1992a) state, it is important to account for the locally determined holistic and dynamic environment in which interventions are centred in order to explain if perceived 'crisis' is seen as a threat or an opportunity. Phase one of the study appears to show the external factors were seen as both. This seemed to have made the Designates and their organisations receptive to a redesigned service. The data indicated that Designates found their environment stressful, but when a compelling vision and freedom to work together was presented they engaged positively; this corresponds to Mackay *et al*.'s (2004) HSE work which noted stress can lead to collaboration. Phase two found that the Designates responded to the Network's good reputation (gained from its success at resolving joint concerns) by engaging with Network colleagues and adapting to a team perspective. Similar was seen in Berg & Hallberg's study which found reflective dialogue on *'practice as well as the process of confirmation of competence'* within groups develops not only an individual's sense of worth but friendliness and respect for their peers (2000:125).

The change was a radical departure from the previous system, the drawbacks of which had been accentuated by the interplay of external factors. The study found that when the Designated professionals were brought together for the first time they were exposed to a transformational leadership style and a supported change process, which appeared to expedite the creation of the Network. The action learning process canvassed their opinions, inspired a vision and created ownership of that vision. The innovation relied on trust and respect for each other, to support and empower them as individuals to devise a different, more collaborative way of working together to jointly shape a structure and operating framework which addressed their concerns.

Management theories advise that the *'most important resource of an organisation is its people, so how people are organised is crucial'* (Johnson & Scholes 1999:401) and for several decades organisational strategy has advocated processes to manage change (Anderson 2010; Blanchard 2007; Drucker 1999). There is extensive literature on change management, though it is recognised that change fails two times out of three (Sirkin *et al*. 2005; Beer & Nohria 2000), because change needs long-term effort, commitment and integration into the operational framework. One suggested causal factor is a high frequency of change, which can generate cynicism and hinders staff's ability to engage (Reichers *et al*. 1997).

The work of Kurt Lewin in the field of psychology linked change management and action research (Schein 1988:239) and shares the idea that in normal conditions behavioural change is slow. However when conditions are volatile the *'established routines and behaviours break down and the status quo is no longer viable; new patterns … can rapidly emerge and a new equilibrium formed'* (Burnes 2004:982). Pettigrew *et al*.'s (1992b) study of change in sixteen hospitals state that '*top-down pressure… married with bottom-up concern'* (*ibid*:28) could support transition alongside other factors. They conclude that the success of change was '*contextually sensitive'* and with increased receptivity the '*availability of key people'* to lead change was critical (1992a:278). Pettigrew *et al*.'s study was dismissive of the notion of a 'transformational leader', linking it as they did with the idea of a charismatic individual. However their study described as important to the success of change those behavioural traits attributed to transformational leaders as noted in Kouzes & Posners' (1995) model. The current study appears to support the notion that leadership together with a clear and appealing vision was able to benefit from uncertainty in the external and internal environment to transform the local circumstance in which Designated functions were delivered.

The joint identification of problems and self-mediated solutions are aspects of both participatory action research and transformative leadership behaviours, as these address the 'harder' elements of change, such as offering support to Designates in the extra effort they need to achieve new skills and adapt. Progress on the crucial Board-level agreements which would codify the Designates' ability to work across organisational boundaries was communicated back to them regularly. Such practices increased a sense of ownership for the Network (O'Driscoll *et al*. 2006). Within the forums' group reflection equity of status was forged; with a shared vision and open access to knowledge, the collaborative network seemed to transform how Designated professionals saw their roles, a process noted in Butterworth *et al.* (1999).

Findings from the first phase of the study showed that as the NHS reforms changed the environment, Designates unexpectedly found the 'status quo' altered, with their historical pattern of practice curtailed and their role distanced from frontline provision. The Designates' remit was refocussed to fit the new ethos of practice improvements through clinical commissioning. Supported by the Chief Officer and PCT/CCG Board agreements, employment issues and continuity of service were secured. The study found that leaders' transformational behaviours enabled the Designates to build change from the ‘bottom-up’. This created ownership in a shared identity of a Designated professional who had a strong and informed clinical focus, and who worked together to devise locally relevant solutions. The Network’s evolution involved many factors including a pluralistic leadership which allowed stability and support through the change. The transformative alternative vision with strong clinical values, openness to learning and flexibility across organisations licensed *‘groups to buy into the change’* (Pettigrew *et al*. 1992a:28).

The study appeared to find that the Designates’ commitment created a platform from which they envisaged a solution based on a shared identity and trust in a changed but clinically led model. Pettigrew *et al.* (1992b) found transition was support if management and workforce pressures coalesced around a solution. The Network’s evolution included these factors with external support, the stability gained from pluralistic leadership of four professional leads and a broad alternative vision which encompass individuals’ interpretations. Also as seen in findings from the Network, Pettigrew also found strong clinical values, openness to learning and flexibility across organisations aided successful change.

Relief of stress

While the excitement and stimulation by change has often been seen as a motivator for personal growth, the negative biological responses to anxiety and stress dominate the literature, where changes in the workplace are recognised as eliciting the same emotional responses as feelings of risk and threat (Siegrist 1996). These are known to alter our psychology, reducing our ability to respond well, analyse or predict outcomes (Hobfoll

1998). While Peckover *et al.* (2015) interviewed four Designates on the emotional labour and stress of undertaking Serious Care Reviews, there is no other research focussing specifically on stress in Designates. Other studies examining stress in nursing found the perception of isolation from colleagues, of being the 'only one', and working in emotional situations provoked significant stress responses in staff (Valaitis *et al*. 2011; Kushnir *et al*. 1997). During the pre-Network phase, Designates reported that their solitary role was stressful, whereas in phase two the offer of group supervision and reflection connected them, encouraged trust, respect and friendliness and alleviated the stress of isolation (Francke & Graaff 2012).

Throughout the study, Designates distinguished between the stress and anxiety caused by the changing demands of their new role exceeding their abilities (Siegrist 1996) and the stress caused by the unpredictable outcomes of child protection work. Salas *et al*. (1996) argue that '*undesirable emotional and cognitive*' stress is caused when work demands exceed personal resources. The findings may reflect how the Designates drew on their own expertise and familiarity with safeguarding work to assuage the stress inherent in child protection practice. In phase two, Designates stated they were stressed by being ill-equipped and unable to meet the demands for 'new corporate skills'. Designates regarded the Network's support for developing a corporate skill set as one of its benefits.

Designates in the study expressed their worry of 'getting it right' for children, though this was not the area of concern they stated they were ill-equipped to deal with. Studies have shown that the performance of experts is not decreased by stress, rather they tend to shed non-priority tasks and ensure that critical issues take precedence by narrowing their focus (Serfaty & Entin 1993; Kontogiannis & Kossiavelou 1999; Dorner & Pfeifer 1993). This was echoed in findings from phase one which illustrated how stress appeared to have prompted the Designates to use the managed change process to create a team which could prioritise the most pressing key issues to improve practice. In phase two, Designates used the team approach at forums to discuss high profile issues; this allowed them to develop a repertoire of skills before demand required them to prioritise and shed tasks, as one noted '*storing it up for when you do need it'* (W322).

Research indicates that our desire to 'turn off' the stress and anxiety caused by change makes us more willing to seek and adapt to new, alternative environments (Ursin 2004). It is suggested by Burnes (2004) and Lewin (1947) that our previous modes of operation become less effective and when environments are in flux, our resistance to change is overwhelmed; this accords with the experiences of the sole practitioner Designates in phase one. As with the Network's increases in resources and capacity, if an alternative vision is offered – which controls stressors by providing a supportive reflective team approach, models coping strategies, and offsets excessive demands with extra capacity – people rally behind the solution. This can provide the impetus to innovate as seen in Lewin's change management model (Hobfoll 1998; Meurs & Perrewe 2011; NIOSH 2000; Hammond 2000).

Feeling supported

The concept of 'support', while hard to define, was used by Designates in relation to many factors. In phase one, the Designates were sole practitioners, and they indicated an absence of support and reported feeling ‘cut off’ from frontline staff: one respondent described Designates as “*an elite club of just you*" (X46). Studies have found isolation from colleagues left staff feeling unsupported and that workers valued being socially integrated within groups as it allowed them to feel emotionally supported (Plews *et al*. 2005; Rooke 2015; Collins *et al*. 2000). The Designates in phase two noted that having colleagues allowed them to informally ‘talk through’ issues and that such joint reflection acted as learning as well as reducing stress and was an adjunct to the formal supervision and peer review offered by the Network. This ‘buffering’ effect increased their ability to cope as groups can bolster self-esteem and provide reciprocal help and information by enabling staff to ‘talk things over’ with colleagues (Barrera & Ainlay 1983; Plews *et al.* 2005). Sheaff *et al.* (2012) also found supportive informal connections encourage individuals to engage.

Phase two of this study showed that despite the Designated nurses’ and doctors’ accountabilities and core responsibilities having increased not lessened, they confirmed the inclusive, mutually supportive and reflective allegiances they formed in localities and across the county helped them: *“I sleep better knowing that I'm not alone carrying all of this”* (W322). The Health and Safety Executive (HSE 2009) and NHS (NHS III 2013) guides to tackling stress recommend workplaces should enable staff to ‘have a laugh’ and ‘talk things through’ with their colleagues. This had not always been achievable for Designates. A finding from phase two – “*because there is support, you can use others to check [things]”* (W39) – reflects literature on emotional intelligence and group supervision (Ballet & Campling 2014). This suggests social connectedness, including encouragement from colleagues, supervision or joint learning, provides outlets to discuss worries and therefore reduces stress (Barrera & Ainlay 1983; Marrow *et al.* 2000; Morrison 2006).

6.3.2 Finding B: Collaboration enhanced practice

Innovations were achievable only through team work

The professional forums acted as a '*communicative space… [which] permits people to achieve mutual understanding and consensus*' (Kemmis 2001:100). Group discussions and reflections facilitated the Designates to achieve their joint objective of consistency in safeguarding practice by devising shared solutions (Spence *et al.* 2002). Stoecker (1999) suggests democratising the knowledge creation process, as seen in the Network's first year, acts to compel the continuation of a mutually beneficial relationship, an idea also seen in theories of social capital. Designates recognised some improvements had only been achieved by collaboration: examples include the county's GP training; a project to update Health's entire vulnerable children information database in collaboration with children's social care; and level three competencies training delivered to 250 University-based nurses.

Joint reflective learning and supervision

A principle of the Network was to offer opportunities for joint reflection and supervision to improve consistency of advice and practice and support access to knowledge. The need for this aspect was seen in such comments as: *'There is no one … to take concerns to'*, *'don't meet with others in the field'* (X65) and *'no place to learn what the current thinking is'* (X12).

While formal supervision and peer review provided the necessary governance required by the Network board, it was also a requirement to ensure competence in safeguarding/child protection practice as it ‘*promotes a safe standard and excellence of practice’* (RCPCH 2014:65). The way Designate doctors and nurses engaged with formal ‘hierarchical’ supervision varied. The nurse professional leads used a one-to-one approach with a joint aim of case-management and support. This appeared to be appreciated by the nurses: “*You can get stuck on small issues rather than looking at the broader issues, and the professional leads have helped with that”* (W*). Though concern was expressed: *"You have to be careful keep checking … ultimately it’s your decision”* (W*). These indicate similar sentiments to Platzer *et al.* (2000)*,* Carver *et al*. (2014) and Peckover *et al.* (2015) studies where nurses valued the supportive and educational aspects of supervision but were reluctant to expose their decisions to judgement.

In contrast, the doctors in the study held peer review meetings, in which they reported benefitting particularly from discussions of safeguarding practice. The Network forums mimicked the positive aspects of the flat structured peer review and provided a safe environment to both examine their views and to learn from others: *“people are treated as equal, even though some obviously have far more experience than others*” (W322). Doctors commented that their practice benefitted from the nurses’ detailed knowledge of guidance and systems surrounding emerging issues, a finding similar to Landmark *et al.*’s (2003) study which found supervision was able to bridge the theory and practice gap. The Network’s informal or ‘flat’ supervision or reflection structure appeared to be more acceptable and welcomed by the Designates. This was illustrated by comments such as “*I like the fact we have meetings…the discussions drive up standards”* (W322), “*there are always people around you can use as a sounding board to check out your thoughts”* (W572) and “*It is* *simplistic, but having others who know the answers allows you to feel sure about yourself, it is a library on tap"* (W732). These may indicate that the flat structure operated at the forum increased confidence (Marrow *et al.* 2002), supported a deepening awareness of practice (Spence *et al.* 2002), and showed increased levels of engagement (Butterworth *et al.* 2008). The opportunity to safely debate their work challenges was also provided by one-to-one supervision with the professional leads; the data appear to indicate Designates found this useful as an educational and supportive device (Butterworth *et al.* 1999 & 2008).

Shared strategic vision

As part of the inter-organisational process to establish the Network, and in reference to the CQC's finding, the PCT Boards and partners developed a strong strategic vision. Studies have shown that a compelling vision of the future which offers a sense of psychological safety (Cameron & Green 2009:57; Schein 1988) can offset anxiety. Phase two found that the Designates appreciated the Network's articulated strategic plans; this was particularly significant for looked-after children specialists as there had been no previous joint direction. Though, as Edwards (2002) found, if the direction is in conflict with the prevailing view, it can have a destabilising effect, as seen in the Network manager's alternative direction.

The study showed that all Designated doctors or nurses had a common professional background. Research in healthcare settings notes that teams are quicker to reach common understanding and decisions the more team members have in common, although a group's homogeneity also raises the possibility of errors, as it excludes diverse opinions (McCaulley 1975). This study's findings showed that decisions on task prioritisation and the Network's direction generally received full agreement, though professional differences were notable, as doctors who were still 'at the bedside' felt that 'corporate' work was of dubious value: "*We're losing sight of the important issues. So what if the KPI*[30] *for X indicates this or that"* (W*). In contrast, nurses who were embedded full time in the CCG corporate world recognised commissioning as 'slow' to act but thought that "*when it goes right then major improvements can come from that*" (W*).

Their changed role

Of great importance to the Designates in phase one was the distance they perceived had developed between themselves and frontline practice. Though still aggrieved by the imposition of a formal request process and the loss of their close relationship with practitioners, this concern was reported less frequently by phase two: instead, they appeared more sanguine about the separation. The Designates' relationship with providers had always been dualistic, as it required them to act simultaneously as a knowledgeable and supportive practice colleague, and as the assurer of quality. When the NHS reforms changed that balance and their strategic role took precedence, as in phase two, the nurses' earlier rejection and hostility to the idea of monitoring for improved practice through data appeared to decrease alongside their growing confidence.

Marketization had increased the need to monitor health services' outputs; however, these were not value-neutral: '*A set of child welfare performance indicators contains implicit values about what is important in practice'* (Tilbury 2004:226). The Designates reported that the construction of meaningful indicators posed a dilemma as they would set how child

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[30] Key performance indicators

abuse was defined, which echoed the concerns regarding statistical thinking (Turmel 2008). Quoting from the Munro report, '*Not everything that can be counted counts, and not everything that counts can be counted*' (DE 2011:61), some were prompted to ask whether what they were monitoring would actually make a difference to children’s lives. A nurse stated that counting ‘patient contacts’ prioritised the corporate assurance, and was a major over-simplification of the immeasurable problems encountered in safeguarding.

The Network’s aim had been to address the priority concerns of safeguarding practice and to improve professionals’ expert knowledge. The Designates’ initial inexperience in commissioning created further demands as they reported feeling inadequate in ‘corporate work’ and of having an urgent need to acquire business skills in addition to their clinically-based repertoire. As the demands for the new skills increased, they were less disposed to retain their previous working habits, in the process Lewin (1947) referred to as ‘unfreezing’. Schein (1988) suggests the retention of one’s ‘old’ identity while performing a new role becomes unsustainable when the discomfiture caused by lacking the useable skills and necessary knowledge becomes too great. The Designates’ transition may have been helped by group supervision and discussions as seen in their use of less hostile language in phase two. The next stage of Lewin’s process of change suggests new skills are learnt by trial and error and an altered identity is absorbed which better fits the new governing concepts.

Similarly, Stevens & Hassett (2007), in their study of complexity theory in child protection, state that small systems, such as the Network enclave, do not have enough internal strength to withstand the pressure of being different from their normalising environment. This was also found in the Scottish studies (NHS SDO 2004). Over the course of the Network's first year, the Designates adjusted to increasingly see their CCG as their team and commissioning as their practice. The new status quo became slightly at odds with the Network's original aim, which caused it to become dissipative and so demanded more energy from them.

Phase two found that Designates were tested when seeking to communicate their specialist knowledge to commissioners. Previously they had attuned their 'conversation' by using a shared terminology as seen in their work with frontline staff. Designates felt this mode was at variance with the technical concepts their new role needed to communicate as 'commissioners speak a different language'. The Designates' new strategic relationships had forced them to think in the rational, linear way strategy demanded (Morrison 2006) and they struggled to adapt their communication patterns to the ordered approach required.

6.3.3 Finding C: The Network augmented their knowledge and enhanced their skills

Influence

Designates consistently discussed their influence in both their strategic and operational roles. Their ideas covered how they saw themselves as local leaders, the limitations and barriers to influence, including not knowing who to influence. In what may be the legacy of Kempe's approach (Kempe & Helfer 1968), when doctors spoke about their influence, they confined it to their practical skill of acting as exemplars to colleagues. In contrast, nurses spoke about influencing practice as an indirect action, especially since their contact with frontline staff had decreased. Designates' multi-layered relationship with providers meant that while in phase one they had regretted the waning of their influence as advice on practice was filtered through the Named nurses, in phase two they stated their influence on the CCGs' strategy had in turn extended and increased their wider influence on practice. Influence has been considered in a wide body of literature from a variety of fields; this study uses the definition: *'A socially induced modification of belief, attitude or expectation effected without recourse to sanction*' (Willer *et al*. 1997:573). As Designates' strategic leadership role carried no transactional authority, instead they relied entirely on transformative behaviours to influence. Their influence was both 'positional' – less prominent after the reforms as it was gained when providers validated their opinion – and 'expert' as the holder of scarce skills and information. This may have been boosted when the Network received recognition from external professional bodies as it appeared later to have increased the perceived legitimacy of their decisions. An enhanced safeguarding profile generated a higher priority within the CCGs' Boards, Designates reported their advice on strategic direction and commissioning intent was more welcomed. The Network's interdisciplinary model appeared to have benefitted individual Designates as they reported its collective reputation affected the way in which their expertise and opinions were viewed externally. They stated: *"the Network has enabled us to… drive the agenda … our expertise and views are actually now valued and listened to"* (W472). They reported this had not been the case, looked-after children specialists in particular stated that the Network's collective opinion had been beneficial for them.

Knowledge

> *'Knowledge is of two kinds. We know a subject ourselves, or we know where we can find information on it*.' Samuel Johnson (Boswell 1791:418)

Johnson’s adage epitomises how Designates perceived their own knowledge. Their description of the Network as a ‘library on tap’, combined with the team philosophy, gave them the ability to access each other’s repositories of information and knowhow. This applied to doctors and nurses and across specialisms, and contrasted starkly with their prior individual knowledge base. In findings from both phases of the study, the Designates’ reports accord with the research of Fahey *et al*. (2003) which found the three most important values of networks were their ability to maximise scarce resources; improve opportunities for knowledge; and identify expertise.

Designates appeared to differentiate between theoretical knowledge, which they saw as standing behind practice, and their more highly valued competence, which they reported was more than knowledge and it was gained from their individual and group reflections on experience and knowledge (Marrow *et al.* 2002). They used the word ‘training’ to express their requirement for knowledge in areas in which they had no prior experience and for which they had no useable frame of reference. While this applied to emerging child maltreatment issues, the requirement of their new roles’ ‘business’ skills dominated. The ‘urgent’ and ‘steep learning curve’ they felt they were on had escalated between the two data collection phases as corporate demands increased. According to Kolb: ‘*Knowledge results from the combination of grasping experience and transforming it’* (1984:41). Kolb *et al*. (2011) stated that professions exert enormous pressures on professionals to be competent practitioners and nursing’s ‘*concrete experience/reflective observation’* learning style reflects this. This might account for the pressure Designates described when providers erected barriers which effectively blocked their contact with the frontline practice.

As competence is a combination of knowledge, performance, skills and attitude on a continuum, it can also act as concise performance measures which '*attenuates the tension of interests between the employer and educator*' (Cowan *et al*. 2005:355). The NMC code requires practice to be based on competence of actions supported by knowledge, and includes child protection competencies (RCPCH 2013). These specify that Designated professionals are required '*to be able to apply in practice: Advanced and in-depth knowledge'* and to 'know how' to use their expert knowledge to influence strategy (*ibid*:72).

Designates described a process similar to Argyris & Schön's (1974) 'double-loop learning cycle', in that reflection on the outcomes or consequences of their actions or advice during supervision and peer review helped them reframe problems. Designates undertook this in real time by seeking feedback from practitioners on the advice they had given, through reflection during appraisals, or more frequently via supervision. Its importance is demonstrated in legislation: '*Supervision should support professionals to reflect critically on the impact of their decisions on the child and family'* (DE 2015a:25). In the Network, which operated to provide a source of support and knowledge, formal and informal supervision was valued: *"There is always somebody to go to and ask and somebody who knows"* (W732).

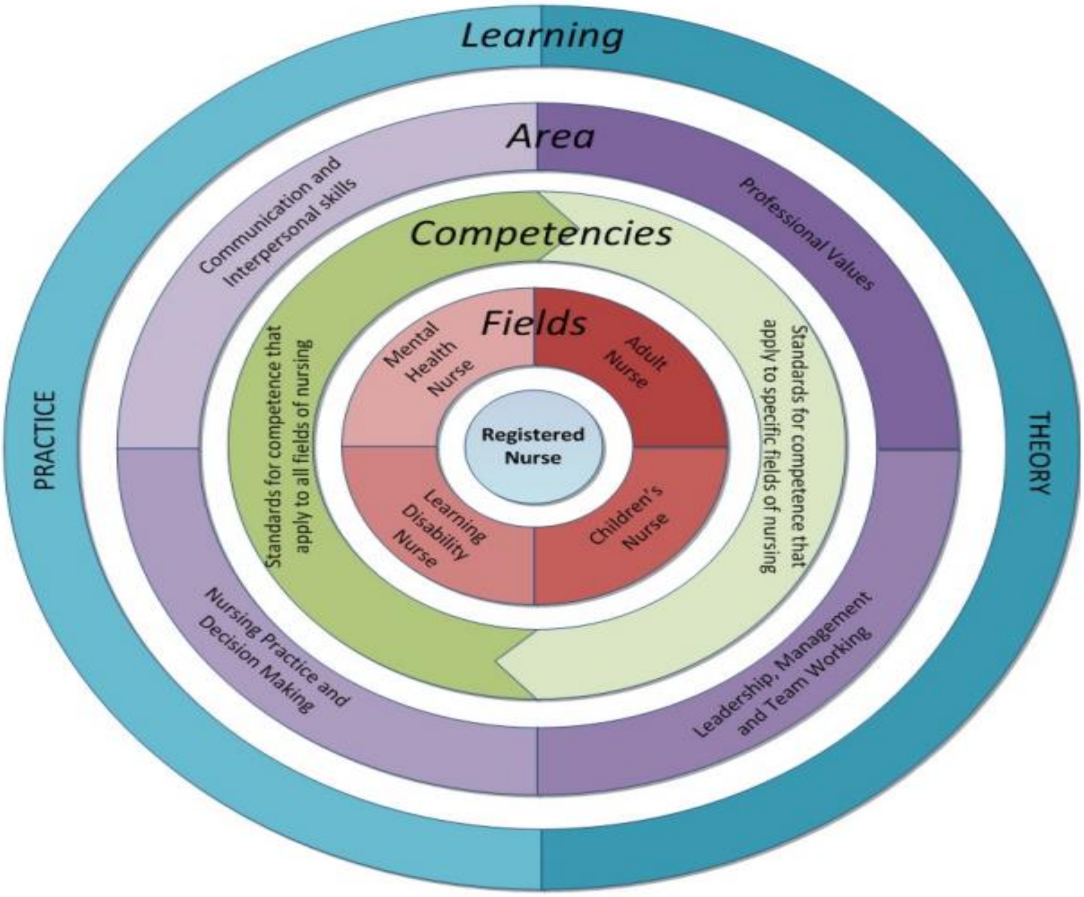

Figure 10: Standards for competence for registered nurses, The Nursing and Midwifery Council Code of practice (NMC2004)

Expert decision-making

The Designates described that decisions about actual patient care or interventions required them to draw together experiential and formal knowledge with emotional intelligence. Assessments needed to take account of complex ‘variables’ at play from the patient’s past, present and future life, to base care on indicative, not predictive outcomes. As complexity theory acknowledges, the only guarantee is that situations change unexpectedly, as the system self-organises in a ‘non-linear’ way (Stevens & Hassett 2007:129).

Designates found it difficult to articulate their decision-making process, but described a 'mental map' constructed of various 'governing variables': "*You have [the] legal framework, your knowledge of the system… clinical knowledge and experience"* (W171) and for some this included their code of practice. As predicted by Kowalski & Vaught (2003) the process was characterised by problem detection, diagnosis and the systematic consideration of all relevant alternatives, which resulted in a choice of the best option given the exact needs. Designates did not describe the content of child protection decisions as stressful, but rather their quality and appropriateness being a constant concern: *"The biggest fear is have I made the right decision for that child"* (W39). This appeared to link with their fear of getting it wrong because they did not have all significant information: "*Never knowing the complete picture*" (X46). The 'picture' they alluded appeared to be constructed from the specific situation's 'complex variables', policy and legislation, and outcome feedback gained from multiple safeguarding decisions previously provided by their close contact to frontline. Vicarious experience seemed to extend their personal knowledge and allowed them to be less stressed in similar subsequent situations (Kowalski & Vaught 2003).

Kerstholt (1995) found that decisions made in dynamic environments used feedback on initial actions to fine-tune further actions, trading off the cost of action against the risk of non-action. This may provide an interpretation of their negative response to Named nurses who they felt filtered outcomes: *"They have their own safeguarding intellectual property and are trying to establish themselves"* (W472). The discussions at the forums appeared to evidence this as the group harvested others' experiences and knowledge to act as a surrogate modifier to judge which of their own actions would achieve the best outcomes.

Downie & Macnaughton (2001) question the objectivity of assessments which ‘weigh’ the importance of the known facts, as the judgement is reliant on an individual’s understanding of the situation which cannot be unbiased. The Designates’ relied on knowledge gained from previous decisions, which by the nature of child protection prioritised the avoidance of harm (Goleman 2002). This became unsuited to the predominantly predictive rational linear model required for strategic decisions and may have underlain their initial reported commissioning difficulties. The forum records that the Designates used group supervision and peer discussions to reflect on decisions and instead of relying on past experiences as ‘evidence’, they jointly re-examined hypotheses and sought unbiased sources of knowledge from which to predict a decision’s outcomes (Landmark *et al.* 2003).

6.3.4 Finding D: The balance of resources needed for Network sustainability

The inter-organisational nature of the Network demanded that it was overseen by a board of CCG representatives, with the four professional leads taking responsibility for initial support to the board. Over time the CCGs altered the Network’s governance structure and imposed a regime which required separate performance reports from each of the locality Designates. Notwithstanding that the extra demands arose from their CCGs by way of the Network Board, Designates saw these as burdensome and unfair, and felt they took time from their core practice role and led to an unequal distribution of work. This change in work patterns, and therefore the Network’s focus, led Designates to question whether the commitment and assiduity required to sustain the Network was a productive use of their time. This was seen to have occurred in studies by Guthrie *et al*. (2010), Goodwin *et al*.

(2004), Ferlie *et al*. (2010) and Sheaff *et al.* (2011), who all recognised that the benefits of networks could be stifled or overwhelmed by the bureaucracy imposed by management.

The founding principles of fairness (Beauchamp & Childress 2001) and reciprocity, '*characterized by mutual cooperative investments based on the norm of return expectancy where efforts are balanced by respective rewards'* (Meurs 2011:1044), were the basis for the collaborative Network. Studies show investing high levels of effort to receive low rewards provokes negative emotional responses (Preckel *et al*. 2007; Siegrist 1996), as was shown in phase two where some Designates held similar sentiments. Some Designates latterly appeared to believe that their investment of time and effort was no longer leading to net benefits, as it breached the effort-reward balance (Siegrist 1996). As this effect had not been predicted, no remedial actions to lessen its impact had been taken. Ballet & Campling (2014) state that while networks provide a focus for support, individuals' competing agendas can divide loyalties and cause tensions. In this study, the growth in corporate functions was in competition with a model which began as a practitioner cooperative. This threatened the collaborative nature of the Network in the long term as its usefulness to support practice at the beginning had been overshadowed by the demands of administration.

6.3.5 Finding E: Changes in expectations

The Network had been developed in consultation with the Designates who were content with its structure and objectives. This changed six months into its operation with the appointment of a manager who brought a commercialised vision and sought to reform the

Network as a Social Enterprise[31]. The manager wished to introduce and formalise transactional management by imposing direct lines of responsibility from the Designates to the manager: this would have superseded the way they were managed which was outwith the Network and by their locality. This departure was not agreed by the Designates or the CCGs who, as separate legal organisations, could not sanction the Network to have management authority over their staff. Despite this, the manager's 'command and control' style influenced other aspects of day-to-day practice within the Network. This was at odds with the more transformative style to which the Designates had first subscribed. The Designates were content with the lines of clinical accountability being within the Network to the professional leads and valued both the formal and flat supervision. The facilitation at the forums would often use transformative leadership behaviours to engender trust, provide a vision which was based on the Designates' shared values, and build confidence. Topics which came from the Designates themselves aimed to offer an intellectually stimulating discussion which encouraged people to think deeply and create innovative solutions and, in so doing, increased and clarified their knowledge.

The manager's reimagining of the Network's vision prompted disagreements, and differences emerged which changed the internal relationships and unbalanced the dynamic. The CCG representatives on the Network board demanded greater cost efficiency, and obliged Designated professionals to work on an IT redesign which diverted them from practice towards the business of CCGs. This caused consternation amongst the doctors who felt strongly that this was not their role. The Network's principles were undermined as

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[31] Social enterprise: A term to describe a range of organisational forms. Guided by social objectives, surpluses are reinvested in the organisation rather than taken as profit by investors. A key part of the Health and Social care reforms (The King's Fund 2011).

these demands shifted the focus from improving practice at the frontline. It became evident that while the CCGs' ethos was for clinicians to lead commissioning, they did not agree with the Network's collaborative approach to working alongside providers. Instead they saw the Network as a tool by which they could coordinate and control the professionals as a resource to deliver the CCGs' agendas (NHS SDO 2004; Guthrie *et al*. 2010). This diversion away from its original aims resulted in the Network coming into conflict with the standards by which it was predefined to be judged.

Identity was a further line of difference. As the PCTs were being disestablished and CCGs were still in shadow form, the Designates reported feeling a sense of ownership and identity as a group of professionals who had developed the Network. This changed with the introduction of 'clustering', as Designates reported identifying more closely with their north/south locality cluster, rather than the Network's whole-county approach. In retrospect, this may have affected the prioritisation of lead responsibility work and was a negative indicator of the Network's effectiveness (Provan & Milward 2001).

6.3.6 Finding F: Concomitant indirect pressures

The NHS reforms

Throughout the study Designates reported the continuing negative impact of NHS changes and the lack of clarity on the details of their role. In contrast to the Network's managed change process, there had been no organisational effort to ameliorate the work-related anxiety engendered by the reforms. In the first phase, Designates were affected by all the HSE (2009) taxonomy of work-related stress inducers, which included increased demands;

lack of control and support; unsatisfying work relationships; and role and organisational changes. Designates became increasingly overwhelmed by the excessive demands, alterations in relationships and NHS uncertainty: "*I think these changes are out of control*" (W27). The HSE's guidance requires organisations to offset stress by providing employees with *'timely information; adequate consultation and opportunities to influence proposals';* information on the '*timetables for changes and impact to their jobs*'; and training to support any changes (HSE 2009:9). The data recorded none of these preventative measures occurred for the Designates' outside of the Network's formation process. Butterworth *et al.* (1999) noted group supervision and peer discussion forums can ameliorate the stresses of change, and this may have been seen in the findings of this study.

The NHS Institute for Innovation and Improvement stated the effects of unmanaged change are: '*Strong emotions such as fear, anger, hopelessness and frustration'* (NHS III 2013:4). The findings show the NHS reforms' lack of detail for the future of safeguarding children affected the Designates who felt the uncertain working conditions were a personal threat, as I noted in my reflective diary: '*people are worried that 'Working Together' not being published is a bad sign for their jobs'* (November 2011). These negative feelings were reaffirmed by their professional bodies, whose narratives characterised the changes as revolutionary, imposed without justification, and burdensome, which can generate feelings of disengagement and resistance amongst professionals (Dirks *et al*. 1996).

The findings appear to point to the positive effects of the Network in offsetting the Designates' wider concerns. This is supported by research which found networks are more cohesive and effective at times of external pressures and instability (Ferlie *et al*. 2010;

Pettigrew *et al.* 1992b). It may be that the additional uncertainties created by the simultaneous NHS reforms acted in synergy with the transformative leadership in the establishment of the Network, to cement the Network's desirability in the Designates' eyes.

The media

The study showed the Designates had stressful responses to two separate strands of media reports. The findings from phases one and two showed that Designates worried about media reports of child protection work – one stating it was their worst nightmare. They appeared to feel the Network's collective responsibility was protective, and expressed that the ability to 'check out' their advice or actions within a supervisory relationship was beneficial. The Network facilitated extensions to knowledge in emergent areas, which seemed to offset Designates' anxiety. This was evidenced in their discussions at forums on how the county could response to unrecognised child sexual exploitation (Carter 2012).

Other worries noted at the forum discussions appear to have been confined to the uncertainty during the time of the reforms, and were discrete and personal. The findings indicate the media-promoted image of the NHS in need of rescue from its own staff fostered by the white paper title, 'Liberating the NHS', had negatively impacted the Designates' view of themselves. They worried about being judged a poor practitioner, and recounted how this was stressful and lowered their morale. The government's dialogue set a hostile interpretative framework (Entwistle & Sheldon 1999) of poor care which was visible in the then-Secretary of State for Health language when he spoke of 'barbaric treatment' and 'patients being abandoned' (Daily Mail 2011). The narrative of NHS staff as incapable of caring for patients appeared to play on the minds of the Designates whose specialism in child protection had already sensitised them to accusations of poor practice, one doctor stating: '*we have gone from being vulnerable in the media to being very vulnerable*' (W*).

Another concern was that the reforms might abolish their posts. The media's use of '*distorted, exaggerated stereotypes which bear tenuous relation to social reality*' (Briggs & Cobley 2002:307) can undermine health staff with an antagonistic template targeted at them as individuals (Kitzinger 1996 & 2000; Ayres 2001). The same day as Lord Hutton's review of public service pensions found there was an 'unfair' distribution within their pensions and stated that 'it is mistaken to talk about *"gold-plated"* pensions as being the norm' (Pensions Commission 2010), the Evening Standard (2010) linked those separate findings to create a narrative hostile to NHS staff. Despite being incorrect, this idea was swiftly accepted and repeated across media and was used as 'rhetorical shorthand' (Kitzinger 2000) to frame a hostile opinion. Davies & Tallis (2013) argue that as political narratives are unchallenged such media reports encouraged a distorted view of reality in NHS staff as well as the public. Though the Network could not assuage such concerns, its forums and network of contacts allowed the Designates to air their worries, which in itself eased their impact.

The demands of child protection

Alongside the new areas of practice that emerged during the study, there were many child safeguarding documents from government which required the Designates' attentions. In the twelve months before the Network launched there were 98 Department of Education directives, and during its first year a further 166, including fifteen pieces of statutory guidance. The study found Designates were greatly concerned about the implications of the Munro review and keeping up to date, and they reported a reliance on the forum as the space where together they could discuss how to address the issues across the county.

6.4 Evaluating effectiveness of the Network

The purpose of most health care networks is the delivery of direct patient care and the literature on network effectiveness reflects this with many using the quality of service delivery (Guthrie *et al*. 2010), governance (Mannion *et al*. 2010), or delivery structures (Ferlie & Pettigrew 1996) as indicators of success. However, these studies' measures did not apply in full to the Network under consideration here, which aimed to provide mutual support and increase knowledge by collaboration. NHS Service Delivery Organisation (SDO) (2004) defined types of NHS networks by their structure as 'enclave, hierarchical, or individualistic'. The Network in the study had its origin as an enclave with a '*flat internal structure based on shared commitments'*, though governance had demanded that CCG representatives oversee a formalised inter-organisation agreement (Proven & Milward 2001). In phase two of the study, it is shown that the CCGs' wish to oversee the resource by '*authority to regulate the work of members via joint provision*' (NHS SDO 2004:3) created a pressure on the Network to revise its structure to fit their transactional requirements. The study showed a tension between the CCGs' wish to control their resource and the Designates' desire to collaborate to increase knowledge and support. This difference pitted Designates' loyalty to the work demanded from their CCGs against their own needs, and this affected the Network's integration.

The interpretation of findings was aided by the use of Turrini *et al.'*s (2010) framework of network effectiveness, which incorporated criteria from 92 studies on network effectiveness into the schema developed by Provan & Milward (2001). The resulting typology used five broad headings which each held detailed indicators, though some related to client outcomes. Several indicators were chosen to assist the judgement of the Network's performance, including: a network's ability to reach stated goals; its capacity for innovation and change; its long-term sustainability and viability; ideas of quality and service; and community access, distribution and participation. Many of the determinants Turrini *et al.* discussed feature in the development of the Network and in phase two, including:

Feature	**Example from the Network**
Previous collaboration	Seen during the developmental phase
Managing capacity	The sharing of topic lead responsibilities
Time spent interacting	The Network forum, development days and business meetings
Buffering and nurturing	Reported by the Designates as supportive features of the Network
Shaping the operating context	The forum's action research and revision focus
Clinical leadership and existence of a central coordinating element	The professional leads, manager and Network board
Joint staff activities	Working together to deliver countywide projects, presentation at external events and conferences
Partnership synergy	Homogeneity of Designates' specialisms
Meetings and decision-making processes	Forum consensus on problem identification and solutions

Figure 11: Phase two features which illustrated Turrini's positive network indicators

The Network’s interconnectedness and cohesion showed its effectiveness against many of the indicators above; even before its official launch there were positive effects on staff tenure, organisational links, and reciprocity of support. Designates in phase one appeared to welcome the professional leads’ clinical and central coordinating role as a point of stability and continuity in uncertain times. Phase two found for the Network’s first fifteen months its effectiveness was positive against Turrini’s indicators. The situation only began to alter a year into its operation, as the CCGs and the Designates had a better understanding of the demands, and the external threats had decreased. The pressure for Designates to identify with and normalise to the culture of the CCGs appeared to overtake their enthusiasm to remain connected across organisations: “*I don’t give the network its fair share of my time… but my patch is the priority*" (W732). However, they continued to value the support and their ability to increase knowledge and tap into the library of previous experiences that their colleagues held. As Provan & Milward (2001) found, as a network’s external situation stabilised and a positive communication pattern was established, the benefits originally felt by the participants would effectively be negated.

6.5 Limitations

For the academic process a large amount of literature surrounding the primary focus was reviewed and this had the potential to influence my conceptualisation. The lack of previous specific research also meant there was no ‘off-the-peg’ methodology to follow, nor any existing scholarship to act as a guide against pitfalls or point to elements demanding closer scrutiny (Huxham 2003). As I was employed as the lead Designated nurse it was not possible to avoid grey literature, as it was my role to interpret the government guidance and legislation as well as documents from child welfare agencies. The media output on the topics of child protection, the failings of workers, and the effects of the NHS reforms was also largely unavoidable and over time will have affected my analysis.

The study had a number of weaknesses which included its embeddedness in the time, place, and context of the intervention at its centre. The PAR methodology has detractors incorporating as it does the notion of human fallibility in interpretation (Hammersley 1992). One criticism of its stance is that *'findings are veritably influenced by the researchers' perspective thus making it impossible to conduct objective, value-free research'* (Snape & Spencer 2009:17). A potential criticism is that my lack of distance from the Network model could have distorted my objectivity. While I carried no managerial authority over my colleagues, some may have perceived power imbalance, as I was well known, had become a professional lead and had worked on remodelling the service. However, on reflection, I had endeavoured to put in place strategies in an effort to negate the possible effects. This included taking a sabbatical from my role during the interpretative stage to gain distance.

Phase one data was collected as part of the change process and might have reflected the organisation's aims, by having created a prism through which the individual Designates observed the issues and formulated their responses. The limitation of the data used was the brevity of recordings, though these were augmented by the researcher's reflective diary. In neither phase did all Designates participate in the study, so the findings are not able to represent all views. This lack of universal participation might be seen as affecting *'the legitimacy of any conclusions and decisions reached by participants'* (Kemmis 2001:100).

Though the ‘professional forums’ acted as the space where assumptions were checked, the study’s circumstances mean that it is not replicable (Buchanan and Bryman 2009).
Is this study generalisable? For the reasons outlined above and because of the time-bound specific local and national circumstances, the conclusion must be that it is not. Nevertheless, the issues raised in this study are likely to find resonance with doctors and nurses in the NHS who work, or are contemplating working, within a network model.

The final chapter draws together the elements within this discussion to look at its implications for practice and further research.

CHAPTER SEVEN: CONCLUSION AND IMPLICATIONS FOR PRACTICE

The Designated nurse and doctor roles had been delivered in a single post-holder model for their twenty-five-year history. Over this time, the roles' clinical leadership and strategic responsibilities had been enlarged and strengthened, yet the benefits of the model and the experiences of the sole practitioner in post had not been investigated. This research sought to explore the experience of Designated colleagues as they moved from solitary working to operating in a virtual team. As the model developed, the external circumstances were of NHS structural reform and the national reprioritisation of safeguarding. Chapter two's literature review exposed a lack of research specifically focussed on the role of Designated professionals or the National Health Service (NHS) in protecting children, though materials tangential to the study's focus were extensive and significant. My methodological choice of participatory action research (PAR) built on the PCT-led transformative change process the Designates had been through that seemed to inspire collaboration, a shared perspective and a sense of ownership over a network model.

Chapters four and five offered an analysis of the data gained from the Network's documentation, testimonies of self-selected specialist doctors and nurses, and my own reflections as a participant and researcher. In chapter six, I sought to interpret the findings and the relationship between both phases; these were concentrated on six overarching conclusions which answered the research questions. To provide a perspective on the Network's effectiveness, I compared the interpretation with applicable indicators of Turrini's matrix: this showed predominately positive results. While I have defined the study's limitations and lack of generalisability due to the intervention's non-reproducible circumstances, I believe there are general implications to be drawn from the findings. My study did not ask specifically about outcomes for service users, though it was seen in the narratives that outcomes for children were at the forefront of doctors' and nurses' reasoning and they often experienced a dilemma regarding the best way to influence these. Designated doctors stated that their additional time may have been better used in practice treating the child in front of them or modelling the skills required to undertake child protection examinations from which junior doctors could learn (though it must be stated the strategic element of their role was funded separately). In phase two, the Designated nurses had moved their expectation of direct influence to accept that their expertise could still benefit patient care, albeit indirectly. All Designates expressed ideas which demonstrated their child-orientated thinking and the organisational and professional practice recommendations which follow are cognisant of their roles' objective: to improve the life chances of vulnerable children.

7.1 Implications and recommendations for organisations and service users

Effectiveness

While the study aimed neither to prove nor disprove the Network's effectiveness, a network's ability to achieve its stated goals had been used as a measure of effectiveness in studies including that of Turrini *et al*. (2010), which I used to support judgements on the Network in the study. Some of the Network's organisational goals arose from the CQC's anxiety about ambiguity in strategic direction, deficits in Designated professionals' capacity, adequacy in quality assurance methods, and consistency of approach. In contrast, the professionals' goal was to build an inclusive, supportive and knowledgeable network, where they could jointly address safeguarding issues of mutual concern. Literature shows that there has been a tendency for stakeholders – CCGs in the Network – to judge the effectiveness of a network from an individualistic perspective, '*rather than how well services are provided as a result of network activities*' (Provan & Milward 2001:422). In this study the 'top-down' pressures on Designates' accountability within the CCGs diverted resources away from the Network's primary functions. Studies have also found that top-down pressure on professionals risks disharmony and demotivation (Iles & Cranfield 2004; Turrini *et al*. 2010; Ferlie & Pettigrew 1996). This study suggests that there is a threat to the sustainability of the Network if the CCGs' organisational need to manage their resource overwhelms the Network's professionals' goals of mutually beneficial learning and support.

Implication for Effectiveness

The political and financial pressures on CCGs to meet their organisation's demands could have a harmful impact on network arrangements if individual CCGs divert resources away from the agreed joint priorities. The redirection of specialists away from network goals, while meeting safeguarding challenges in one arena, could have unfavourable outcomes for the wider cross-cutting agenda and the network's overall effectiveness.

Recommendation One (Effectiveness)

CCG Boards should incorporate network goals within their individual organisational priorities. To support this, CCGs should acknowledge and limit the demands of generic corporate tasks on the specialists working within the network.

Recommendation Two (Effectiveness)

Organisations involved in network activities should support staff members to recognise their dual priority agendas. Organisations should judge networks and the individuals within them by the productivity and success of their jointly agreed network goals.

Children's lives

The study found that while the many Designates do not deliver frontline services, they all expressed the notion that improving children's lives was central and paramount to everything they did. The data appeared to show that Designates thought that better outcomes for children had been restricted by the piecemeal approach the five CCGs had taken in the construction of service specifications. The Designates reported this approach had led to inaction as 'localism' had stifled negotiations and stretched provision in too many directions. This approach was reported as having weakened the Designates' influence on frontline practice and problematised partnership working in regards to safeguarding and promoting the health of children. The lack of research specifying the connection between commissioning decisions and outcomes of service users will hinder the effective construction of service contracts which targeted improvements in outcomes for children. This deficit must be addressed to ensure that services changes intended to advance care, services and opportunities for children can be delivered.

Implication for Children's lives

Lack of clarity in contract specifications or definitions in the key performance indicators and service outcome measures can impede service progress. The realisation of qualitative changes in children’s lives could be facilitated by commissioning organisations working together to agree the priority service improvements required within countywide contract schedules. For improvements to be assured across the CCGs, agreed qualitative data measures should be implemented for all health providers.

Recommendation Three (Children’s lives)

Evidence of service users’ narrative having made discernible impact on provision should form part of the formal monitoring requirements of provider services’ performance data. An overview of the themes contained within these subjective accounts should be presented and discussed at strategic level Boards to consider their applicability across other services in an effort to ensure opportunities to think differently about services are captured.

Recommendation Four (Children’s lives)

The National Institute for Health Research should undertake research to support the development of service specifications and outcome measures which can accurately monitor if improvements in vulnerable children’s lives have been achieved.

Partnership working

The NHS reforms and the local CQC inspection foregrounded partnership working as a priority. Phase one data found the unilateral development of service specifications by individual PCTs had consequences for partners, as inconsistencies and differences were built into the system, resulting in stagnation of services. Phase two data found collaborative working across CCGs had resulted in closer integration with children’s social care and

General Practitioners. The study's findings supports the Willis report's recommendation that '*inter-professional learning must play a key role in continuing professional development*' (2012:46). The large-scale benefits from interdisciplinary and countywide working were recognised as being achievable only by working in concert. As frontline services are delivered by large providers, the viability of networks to support collaboration between commissioners may increase. Cross-border collaboration has been found to benefit consistency of advice which makes the implementation of change easier for providers. This should be considered alongside coterminosity of borders and the willingness of the CCG Boards to indemnify staff who deliver services in their locality but whom they do not directly employ.

Implication for Partnership working

Improvements in services are slowed when resources are used to negotiate differences between requirements in neighbouring CCGs. The inadvertent consequence of this is to reduce the system's capability to develop productive interagency services.

Recommendation Five (Partnership working)

Neighbouring CCG commissioners should consider aligning their safeguarding specifications across borders to enable and enhance improvements and integration with other agencies. Agencies should jointly interpret performance data to understand the potential for inconsistencies in practice and provision which can negatively affect the lives of families.

Financial

While the study had not sought to explore the financial implications of a network, it is difficult to isolate the findings – particularly the impact on practitioners' time and capacity and the network's sustainability – from the financial climate in which the Network was delivered. Mannion *et al.*'s (2010:28) study of the NHS recognises that there is a need for '*sufficient resource of finance, managerial time and commitment*' to enable change to be managed effectively. Similarly, in two large studies on networks in the NHS – Goodwin *et al.* (2004) and Ferlie *et al.* (2010) – the effects of the transactional costs in managerial and corporate time within network models were either not discussed or not accounted for when the model's effectiveness was judged, despite being crucial to clinical integration.

The political pressure exerted by fortnightly government scrutiny acted to enable the PCT Boards to invest the necessary finances to fund the formation of the Network. This included increasing the staffing levels by seven whole time equivalent (WTE) posts. It is very likely this in part addressed the Designates' concern – expressed in phase one – that they felt overwhelmed. The data shows the Designates were aware of demands for resources as they discussed the deficits in the information technology available to them and their need for an enhanced communications system to aid joint working. The early political imperative for investment had decreased in phase two, and the data suggested the CCG had become more critical in their interpretation of the Network's need and use of resources, evidenced by their desire to redirect Designates' time to a CCG-specific role.

Financial Implication

The coordination and leadership of a virtual team of specialists embedded within individual local agendas requires an allocation of resources dedicated to reinforcing group cohesion. Given the increased complexity of the NHS and the strong pressure on public finances, the benefits of such resource spending should be acknowledged as vital to the productivity and cost-effectiveness of the network.

Recommendation Six (Financial)

Organisations who intend to develop network arrangements should in the future investigate, accept, build in and commit to the financial resource of leadership to support group priorities and cohesion and to the technical solutions needed to provide virtual interfaces, cloud-based secure discussion forums and shared information spaces.

7.2 Implications and recommendations for professional practice

Turrini *et al.'s* study noted an indicator of effectiveness was its potential for innovation. The benefits of the Network's innovative focus on safeguarding professionals had been assessed by the Department of Health who went on to support the use of networks in later statutory guidance. I have had the opportunity to share the lessons learnt with Designates outside the county, and the study will be presented to a wider research audience in the future.

The data found the Designates experienced the Network's capacity for innovation and change in real terms with lead responsibility roles, cross-border working and joint prioritisation of goals. They appeared to consider that the Network's collective legitimacy had strengthened their influence with partners and recounted they were actively consulted by their CCG Boards and provider organisations. The data seemed to confirm Designates valued 'doing' and learning from experience: though they participated in the action research and actively reflected on research findings, they did not seek out opportunities to influence practice by undertaking research themselves. The study showed the nurse participants recognised the breadth of knowledge required to discharge their role, yet some were dismissive of the safeguarding leadership courses they were offered. There appeared to be an inconsistency between their esteem for theoretical knowledge in some areas and their reliance on experience to drive their own practice.

Implication for Professional practice

The literature review found an absence of research carried out by and about Designates has allowed their knowledge to remain hidden: this could be harmful for future practice. While there is reasonable availability of research by doctors focussed on child safeguarding practice, the literature reveals that neither profession has addressed the broader issues of their role. This is supported in two recommendations of the Willis report (2012:45) which state *'a national clinical-academic career structure should be established'* and '*urgent action is needed to support nursing academic workforce and guarantee its future quality'*.

Recommendation Seven (Professional practice)

Health Education England should work with the Royal Colleges to consider the Designated and Named roles' competences, as specified in the Intercollegiate statutory guidance

(RCPCH 2014), in order to delineate the diverse knowledge required, including the necessary business skills. Health Education England should use this to develop approved curricula for Masters and Doctorate level study which focusses on the complexity of directly impacting the service users' lives by the practitioners' expert practice and strategic influence. The programme of study should equip, enable and encourage Designates to undertake research and use their evidence to develop practice.

Shortages in Designated professionals

While there is no central vacancy database for Designated and Named professionals and Named GPs for safeguarding within provision or commissioning, it has been assumed, given the number of vacancies on the health service job websites, that there is still a national shortage. This echoes Buchan *et al.'s* report (The Health Foundation July 2016:6) which states the NHS is currently short of 28,000 nurses, '*as between 2013 and 2015, there had been a 50% increase in nursing vacancies and a 60% increase in doctor vacancies*'.

Implication for recruitment to Designate post

This shortage in nursing staff is likely to impair the ability of providers and commissioners to secure access to the appropriate level of operational and strategic advice they require. Alongside recommendation seven, the day-to-day mentoring and support of Designated and Named professionals is needed to encourage new recruits to take up posts in the specialism. This has in part been addressed by NHS England, whose regional teams facilitate meetings for Designates to jointly reflect on challenges across their area.

Recommendation Eight (Succession planning)

Health Education England through local teams should devise and agree regional professional development pathways which support experiential learning with expert mentorship during the transitionary phase into Designated or Named posts. This will support Safeguarding leadership programmes which focus on transformative skills and behaviours, aimed at inspiring change within frontline practice.

Recommendation Nine (Recruitment)

NHS England and the Health Education England local teams should support the development of networks to work across organisational boundaries as a way to support Designate doctors and nurses meet the challenges of practice, improve access to knowledge and ameliorate professional isolation.

Supervision and Peer review

The Accountability and Assurance framework (NHS England 2015) and the Intercollegiate statutory guidance (RCPCH 2014) both require Designated and Named professionals to receive regular supervision or peer review. Unlike the Designates in the Network, most Designated professionals are sole practitioners and accessing peer supervision which meets the Assurance framework standard can be difficult. As the NHS owes a duty of care to its staff, some NHS England regional teams already facilitate professionals to make connections, though this is an extension to the quality assurance process necessary. The study indicated that Designates felt their stress and anxiety had been ameliorated by their team position and by the legitimisation of seeking solutions through discussions with colleagues. This emotional support seemingly engendered feelings of group cohesiveness, identity and support. Research confirms that participation in a social group can be beneficial for the well-being of sole practitioners as it relieves stress, allows them to feel supported, and aids the development of coping strategies (Rooke 2015; Plews *et al*. 2005).

Implication for Supervision and Peer review

The shortage of accessible, available and appropriately trained supervisors will inevitably hamper Designates' ability to engage in peer group reflection. This will have consequences for practice and would fail to meet the statutory guidance or code of conduct.

Recommendation Nine (Supervision and Peer review)

Availability of appropriately trained and accessible supervisors should be facilitated by the NHS England regional safeguarding lead; this may include support to form virtual networks. This will have the dual aim of challenging Designates' practice by increased access to group supervision alongside building social capital and easing the emotional strain of sole working.

7.3 Concluding remark

The study has been a personal and professional journey which has enhanced my knowledge and understanding of being a Designated nurse and the challenges of being a participant researcher. The study allowed me to go beyond the sparse literature base to engage with other disciplines such as psychology and management theory, which added depth to my thinking. The aim had not been to represent participants' views in full, but to explore issues and offer a snapshot of Designates' experiences as well as my own. The research questions asked about the Designates' abilities and ways of working, and while I had not expected their concerns to be focussed on the lack of 'business skills', on reflection this may have signified confidence in their own child-focussed practice. The Designates expressed their view that team working had addressed some of the challenges they had experienced and working collaboratively had been beneficial for reasons including the support it gave to them as individuals and for their access to others' safeguarding practice knowledge.

While the study's generalisability was limited by the particular environment and it cannot be inferred that any one of the drivers were causal, I feel the study's findings should be of interest to those considering the functioning of networks or those who undertake specialist posts. It is hoped that this study will prompt Designated professionals to relook at their roles and debate if the most beneficial balance between service user directed expertise and strategic input for organisations has been reached. I believe these findings deliver a fresh insight and perspective into an area of practice historically understudied.

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Health professionals Designated and named professionals

2.58 The terms 'designated professionals' and 'named professionals' denote professionals with specific roles and responsibilities for safeguarding children. All PCTs should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the PCT area, which includes all providers. PCTs should ensure establishment levels of designated and named professionals are proportionate to the local resident populations, following any mergers, and to the complexity of provider arrangements. For large PCTs, NHS Trusts and Foundation Trusts that may have a number of sites, a team approach can enhance the ability to provide 24-hour advice and provide mutual support for those carrying out the designated and named professional role. If this approach is taken, it is important to ensure that the leadership and accountability arrangements are clear.

2.59 Designated and named professional roles should always be explicitly defined in job descriptions, and sufficient time and funding should be allowed to fulfil their child safeguarding responsibilities effectively. The Royal Colleges have produced and published a set of safeguarding competencies and job descriptions for these roles. Designated professionals

2.60 Appointment as a designated professional does not, in itself, signify personal responsibility for providing a full clinical service for child protection. This is usually done by a team of professionals. Designated professionals provide advice and support to the named professionals in each provider Trust. Designated professionals are a vital source of professional advice on matters relating to safeguarding children for other professionals, the PCT, LA children's services departments and the LSCB.

2.61 Designated professionals play an important role in promoting, influencing and developing relevant training – on both a single- and inter-agency basis – to ensure that the training needs of health staff are addressed. They also provide skilled professional involvement in child safeguarding processes, in line with LSCB procedures, and in serious case reviews. As part of serious case reviews, designated professionals should review and evaluate the practice and learning from all involved health professionals and providers who are involved within the PCT area. For more details, see paragraph 8.18.

Named professionals

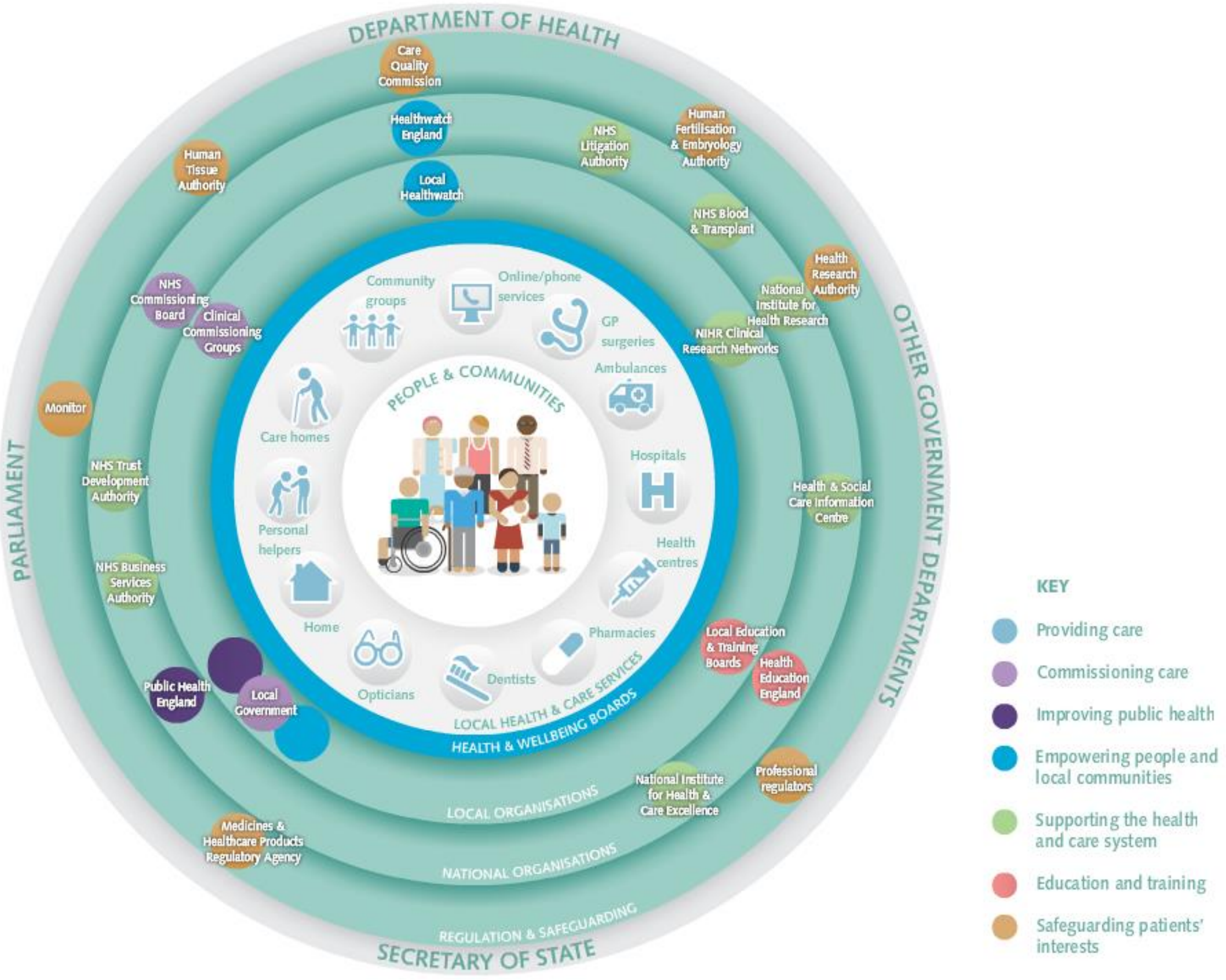
2.62 All NHS Trusts, NHS Foundation Trusts, and PCTs providing services for children should identify a named doctor and a named nurse/midwife for safeguarding. In the case of NHS Direct, Ambulance Trusts and independent providers, this should be a named professional. The focus for the named professional's role is safeguarding children within their own organisation.

2.63 Named professionals have a key role in promoting good professional practice within the Trust, and provide advice and expertise for fellow professionals. They should have specific expertise in children’s health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children.

2.64 Named professionals should support the Trust in its clinical governance role, by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the Trust’s clinical governance system.

2.65 Named professionals are usually responsible for conducting the Trust’s internal case reviews – except when they have had personal involvement in the case, when it will be more appropriate for the designated professional to conduct the review. Named professionals are able to ensure that the resulting action plan is followed up. They also have a key role in ensuring a safeguarding training strategy is in place and is delivered within their organisation.

The Health and care system from April 2013



The Department of Health (DH) is responsible for strategic leadership and funding for both health and social care in England. The DH is a ministerial department, supported by 23 agencies and public bodies.

NHS England

NHS England is an independent body, at arm's length to the government. Its main role is to improve health outcomes for people in England. It:

- provides national leadership for improving outcomes and driving up the quality of care;
- oversees the operation of clinical commissioning groups (CCGs);

- allocates resources to CCGs; and
- commissions primary care and specialist services.

Clinical commissioning groups (CCGs)

Clinical commissioning groups replaced primary care trusts (PCTs) on April 1 2013. CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. CCGs members include GPs and other clinicians such as nurses and consultants. They are responsible for about 60% of the NHS budget and commission most secondary care services such as:

- planned hospital care;
- rehabilitative care;
- urgent and emergency care (including out-of-hours);
- most community health services; and
- mental health and learning disability services.

CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities or private sector providers. However, they must be assured of the quality of services they commission, taking into account both National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission's (CQC) data about service providers.

Health and wellbeing boards

Every "upper tier" local authority has established a health and wellbeing board to act as a forum for local commissioners across the NHS, social care, public health and other services. The boards are intended to:

- increase democratic input into strategic decisions about health and wellbeing services;

- strengthen working relationships between health and social care; and
- encourage integrated commissioning of health and social care services

Public Health England

Public Health England (PHE) provides national leadership and expert services to support public health, and also works with local government and the NHS to respond to emergencies. PHE:

- co-ordinates a national public health service and delivers some elements of this;
- builds an evidence base to support local public health services;
- supports the public to make healthier choices;
- provides leadership to the public health delivery system; and
- supports the development of the public health workforce.

Other health and care organisations

NHS Trust Development Authority supports NHS trusts to improve so they can take advantage of the benefits of foundation trust status when they are ready.

Health Education England makes sure the healthcare workforce has the right skills and training to improve the care patients receive.

National Institute for Health and Care Excellence (NICE) provides guidance and help health and social care professionals deliver the best possible care for patients based on the best available evidence.

The National Institute for Health Research (NIHR) and its clinical research networks form a health research system.

Some of the Bodies which protect the interests of people using health and care services

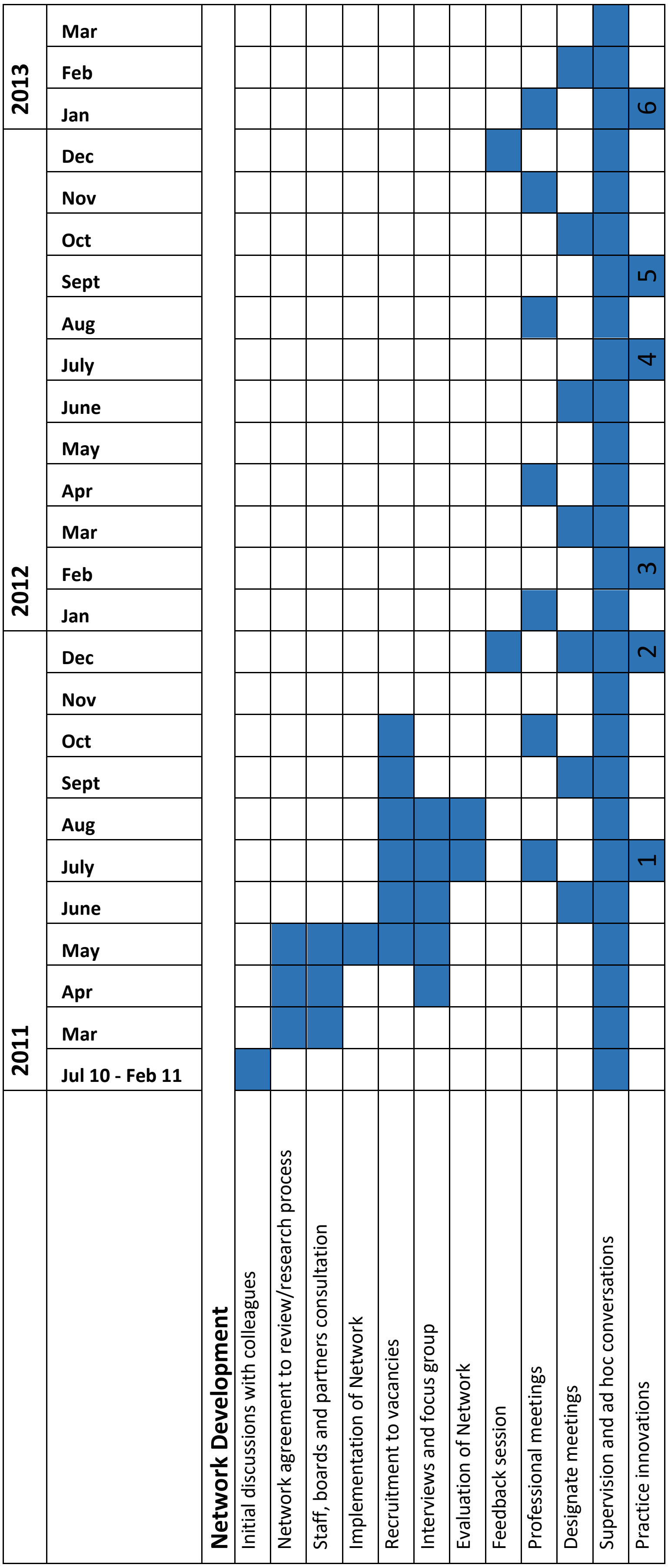
The Care Quality Commission (CQC) measures whether services meet national standards of quality and safety, ensuring that people are treated with dignity and respect.

Monitor protects and promotes the interests of people using health services by making sure that NHS services are effective and offer value for money. Licensing providers of health care will be one of the main tools Monitor will use to do this.

The Health Research Authority works to protect and promote the interests of patients and the public in health research.

Most health and social care professionals must be registered with one of the independent regulators, such as **the General Medical Council,** who help protect patients and public by ensuring that professional standards are met

Online at: http://healthandcare.dh.gov.uk/system/.

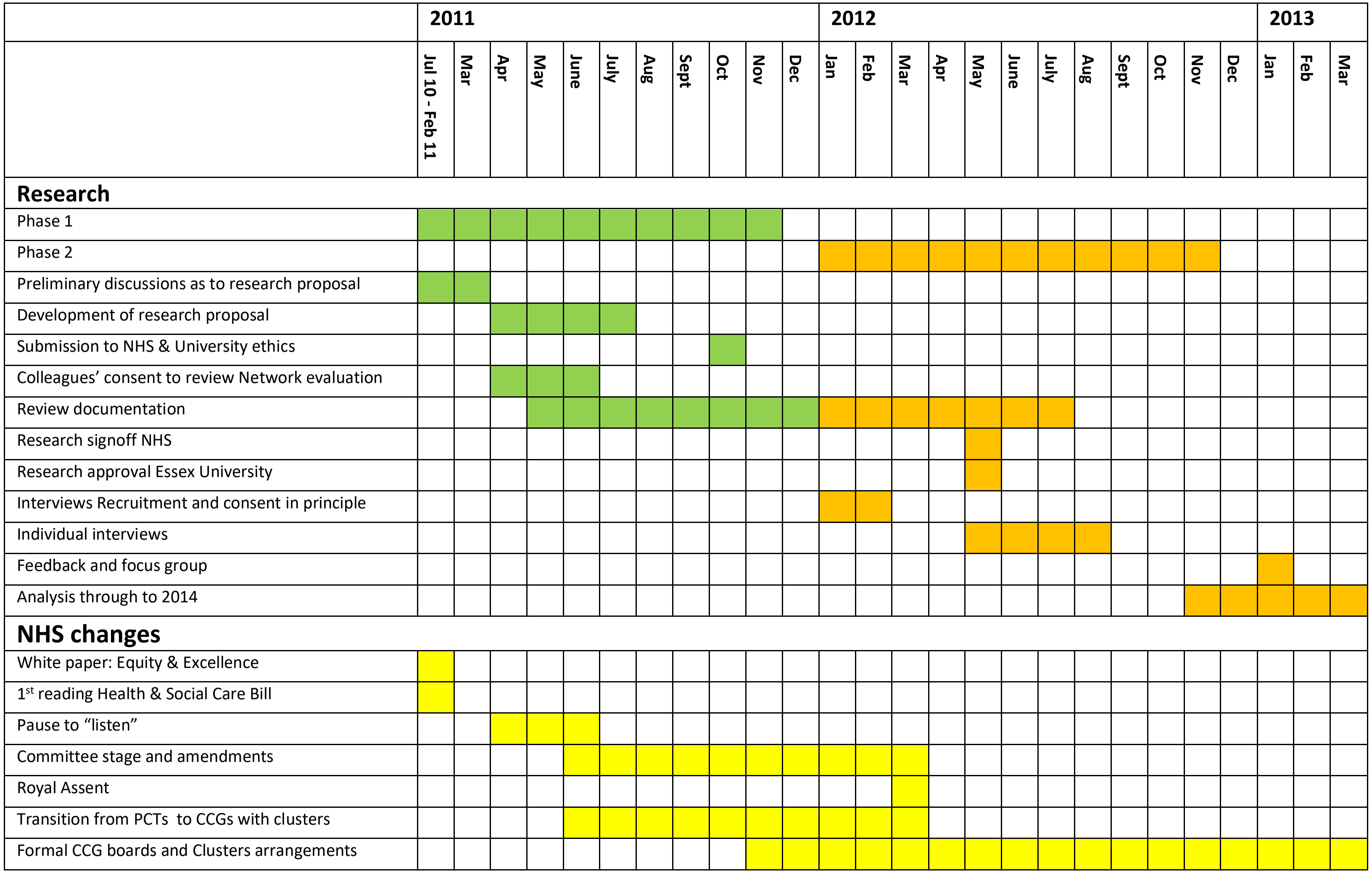


Year	Month	Initial discussions with colleagues	Network agreement to review/research process	Staff, boards and partners consultation	Implementation of Network	Recruitment to vacancies	Interviews and focus group	Evaluation of Network	Feedback session	Professional meetings	Designate meetings	Supervision and ad hoc conversations	Practice innovations
2013	Mar											■	
	Feb										■	■	
	Jan									■		■	6
2012	Dec								■			■	
	Nov									■		■	
	Oct										■	■	
	Sept											■	5
	Aug									■		■	
	July											■	4
	June										■	■	
	May											■	
	Apr									■		■	
	Mar										■	■	
	Feb											■	3
	Jan									■		■	
2011	Dec								■		■	■	2
	Nov											■	
	Oct					■				■		■	
	Sept					■					■	■	
	Aug					■	■	■				■	
	July					■	■	■		■		■	1
	June					■	■				■	■	
	May		■	■	■	■	■					■	
	Apr		■	■			■					■	
	Mar		■	■								■	
	Jul 10 - Feb 11	■										■	

Network Development

Figure 5a: Network development, research progress and NHS changes timelines (part one)

Key	
The Network's operational development	🟦
Phase one of the research	🟩
Phase two of the research	🟧
The 2010 NHS reforms	🟨



	2011											2012												2013		
	Jul 10 - Feb 11	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Research																										
Phase 1	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩																
Phase 2												🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧				
Preliminary discussions as to research proposal	🟩	🟩																								
Development of research proposal			🟩	🟩	🟩	🟩																				
Submission to NHS & University ethics									🟩																	
Colleagues' consent to review Network evaluation			🟩	🟩	🟩																					
Review documentation				🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟧	🟧	🟧	🟧	🟧	🟧	🟧								
Research signoff NHS																🟧										
Research approval Essex University																🟧										
Interviews Recruitment and consent in principle												🟧	🟧													
Individual interviews																🟧	🟧	🟧	🟧							
Feedback and focus group																								🟧		
Analysis through to 2014																						🟧	🟧	🟧	🟧	🟧
NHS changes																										
White paper: Equity & Excellence	🟨																									
1st reading Health & Social Care Bill	🟨																									
Pause to "listen"			🟨	🟨	🟨																					
Committee stage and amendments					🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨												
Royal Assent														🟨												
Transition from PCTs to CCGs with clusters					🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨												
Formal CCG boards and Clusters arrangements										🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨

Figure 5b: development, research progress and NHS changes timelines (part two)

Participant Information Sheet

1. The Study Working Title

Collaborative clinical networks – does this model have something to offer to safeguarding children Designated professionals? Designated doctors and nurses recount their experiences as they seek to change from carrying sole responsibility to working as a virtual team across 5 PCTs.

2. The Invitation

You are being invited to take part in a research study. Before you decide whether or not to take part, 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.

3. What is the purpose of the study?

This research forms part of a professional doctorate being undertaken by Kathie Clibbens at the University of Essex. This will be undertaken using qualitative methods and has the approval of the University's Ethics Committee and the NHS R&D Office. The aim is to report on and understand if the change to the clinical Network method of working has had either positive or negative effects as judged by the professional themselves and other key users of the service. The study will look at the individuals' views, attitudes, experiences and expectations of the change, before the inception of the Network, during its establishment phase and then one year after.

4. Why have I been invited to participate?

You have been chosen to be asked to take part in this research study as you are currently a Designated doctor/nurse within the county, or are closely aligned to the Designated professionals. Your views will be taken as an account of how the changes have affected the way Designated professionals work.

5. Do I have to take part?

Taking part in the research study is entirely voluntary, and 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 be 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.

6. What will happen to me if I take part?

If you do decide to take part, your views on working as part of a clinical network or team of Designated professionals will be captured, looking at views from before the inception of the Network, during its establishment phase via access to the minutes of consultation and development meetings. Your views will also be sought one year into the Networks operation. This will entail an interviews of up to one hour in length. These interviews can either be on an individual basis or in small groups, whichever option is most suitable to you. These will be semi-structured interviews, the interviews will be audio recorded and written notes will be taken by the interviewer. These conversations will then be coded so your name will no longer appear linked to the views. I will be happy to meet you at a Trust location chosen by you if you wish or the interviews will be held at the Trust HQ, where refreshment facilities are available and a meeting room set aside. The possible disadvantage for participants in taking part in the study will be the up to one hour of time that will be required at each of the phases.

7. What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will help to highlight the possible pitfalls and advantages of working within a network, which will go to improving our services.

8. Will what I say in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. The only contact information required will be your NHS email address. All interview recordings will be destroyed at the end of the research, and storage of the information during the course of the research will follow both NHS and University requirements on Academic Integrity of privacy, confidentiality and anonymity. Your name or any contact details will not be recorded on the interview transcripts; instead, a code will be assigned. In addition, any details which potentially could identify you will also be removed or changed. My academic supervisor may request access to your anonymised interview transcripts, but I will be the only person to have access to the original recordings of the interview, your consent form and any of your contact details. Your participation in this study will not be discussed with other interviewees. A code will be assigned to your thoughts in the writing up of the research however this will not identify you to any other reader and I will endeavour to ensure that your involvement remains entirely confidential and anonymous though as some may choose to participate in focus groups this may not be entirely within my control. I am not under an obligation to report anything you say that could be defined as illegal. However, disclosure may be required if you were to say something that potentially indicated that you or someone else was at risk of harm. If you said something of this type, I would indicate this and you could then choose whether or not to continue the discussion. We would also discuss what the next steps would be.

9. What should I do if I want to take part?

If you decide you want to take part in this study, you can contact me, by phone on xxxxxx or by email on xxxxxxxxx. I will explain what the research is about, what will be involved in the interview process and can also answer any questions you might have. You can then decide if you want to go ahead with the interview and we can arrange a suitable time and location.

10. What will happen to the findings of the research study?

The findings of the study will be used in my Professional Doctorate thesis and will (in an anonymised format) be reported back to the Network's professionals and may appear in published articles. The material may well be presented at academic and professional conferences and in academic journals. The findings will also be shared with other interested groups of Designated professionals and commissioners of health services. In addition, a summary report of the findings will be available once the study has finished for all members of the Network. Anonymity and confidentiality will still be in place in all cases. Findings from this study will contribute to developing a better understanding of whether working in a network rather than as individuals has any benefits.

11. Who is organising and funding the research?

I am conducting this research as a research student of the University of Essex, School of Health & Human Sciences. The research has been funded by NHS xxxxx.

12. Who has reviewed the study?

This research has been approved by the University of Essex.

13. Contact for Further Information

You can contact me on the email or phone number above, however if you wish to talk to someone independent of this research study, please contact the Manager of the Network, xxxxxxx, on xxxxxxx. If you have any concerns about the way in which the study has been or is being conducted, you should contact xxxxxx Research Governance and Planning Manager on xxxxxxxx.

Thank you taking time to read the information sheet.

Date

May 2012

APPENDIX 4

Consent Form

Working Title of Project: Collaborative clinical networks – does this model have something to offer to safeguarding children Designated professionals? Designated doctors and nurses in county xxxxx recount their experiences as they seek to change from carrying sole responsibility to working as a virtual team across 5 PCTs.

Researcher: Kathie Clibbens, Consultant Nurse

	Please initial box
1. I confirm that I have read and understand the information sheet 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 reason.	☐
3. I agree to take part in the above study.	☐

	Please initial box Yes	 No
4. I agree to the interview / focus group / consultation being audio recorded.	☐	☐
5. I agree to the use of anonymised quotes in publications.	☐	☐

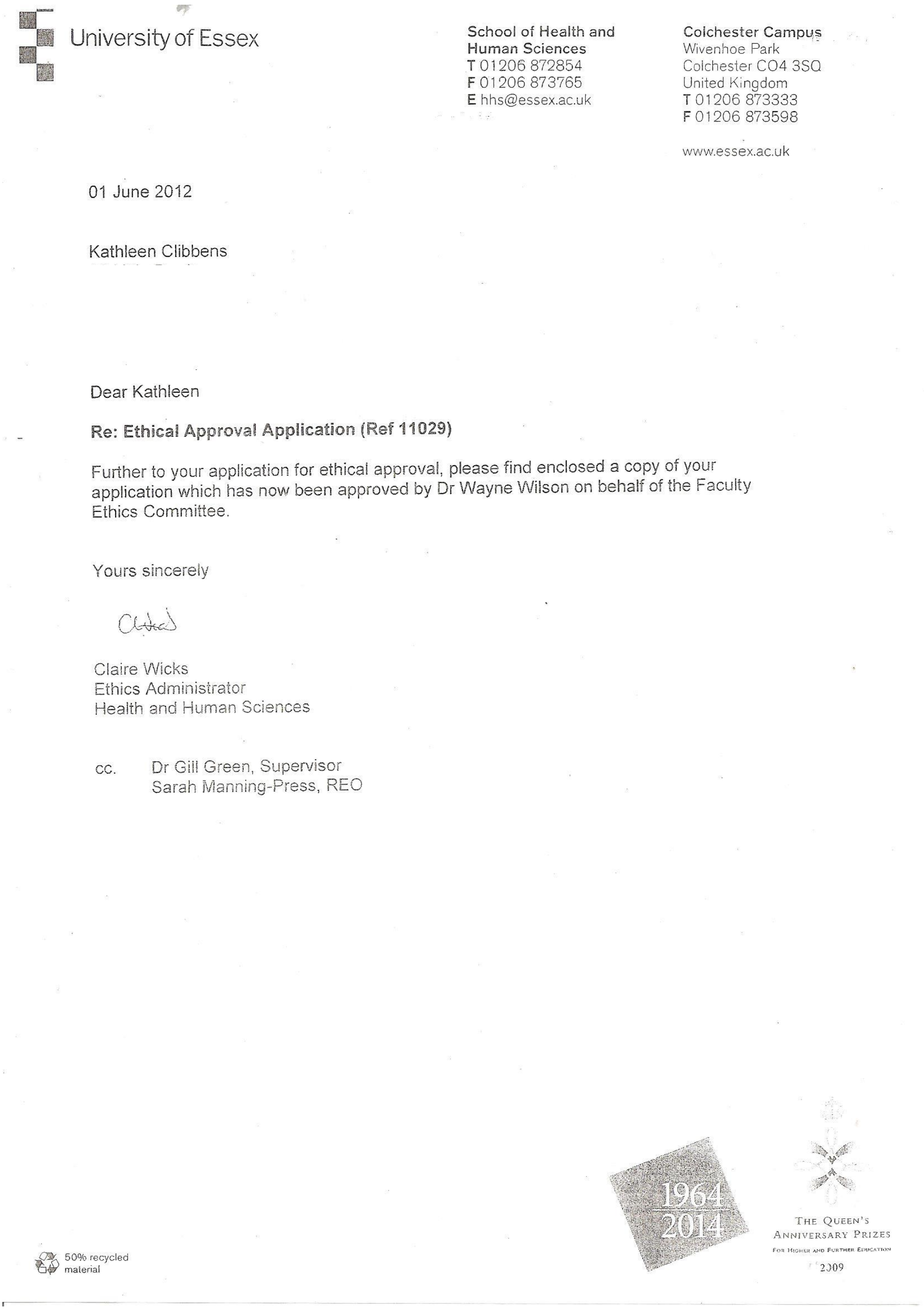
Name of Participant	Date	Signature
Name of Researcher	Date	

APPENDIX 5

The questions asked within the semi-structured format of phase two interviews:

- Could you describe key issues you face when trying to perform your duties?
- What types of decisions do you have to make and how are these taken?
- What do you perceive are the barriers to your work?
- Does your post have influence? What influences you?
- Are there benefits to working as a Network?
- Are they any other aspects which you would like to discuss?

APPENDIX 6



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01 June 2012

Kathleen Clibbens

Dear Kathleen

Re: Ethical Approval Application (Ref 11029)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by Dr Wayne Wilson on behalf of the Faculty Ethics Committee.

Yours sincerely

Claire Wicks
Ethics Administrator
Health and Human Sciences

cc. Dr Gill Green, Supervisor
Sarah Manning-Press, REO

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For Higher and Further Education
2009

APPENDIX 6

University of Essex

Application for Ethical Approval of Research Involving Human Participants

This application form should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research should not commence until written approval has been received (from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then passed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Collaborative Clinical Network: the experience of Safeguarding Children's professionals working within this model. Designated professionals recount their experiences as they seek to change from carrying sole responsibility to working as a virtual team across 5 PCTs in Essex.

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
Do you object to the title of your project being published? Yes ☐ / No√ ☐

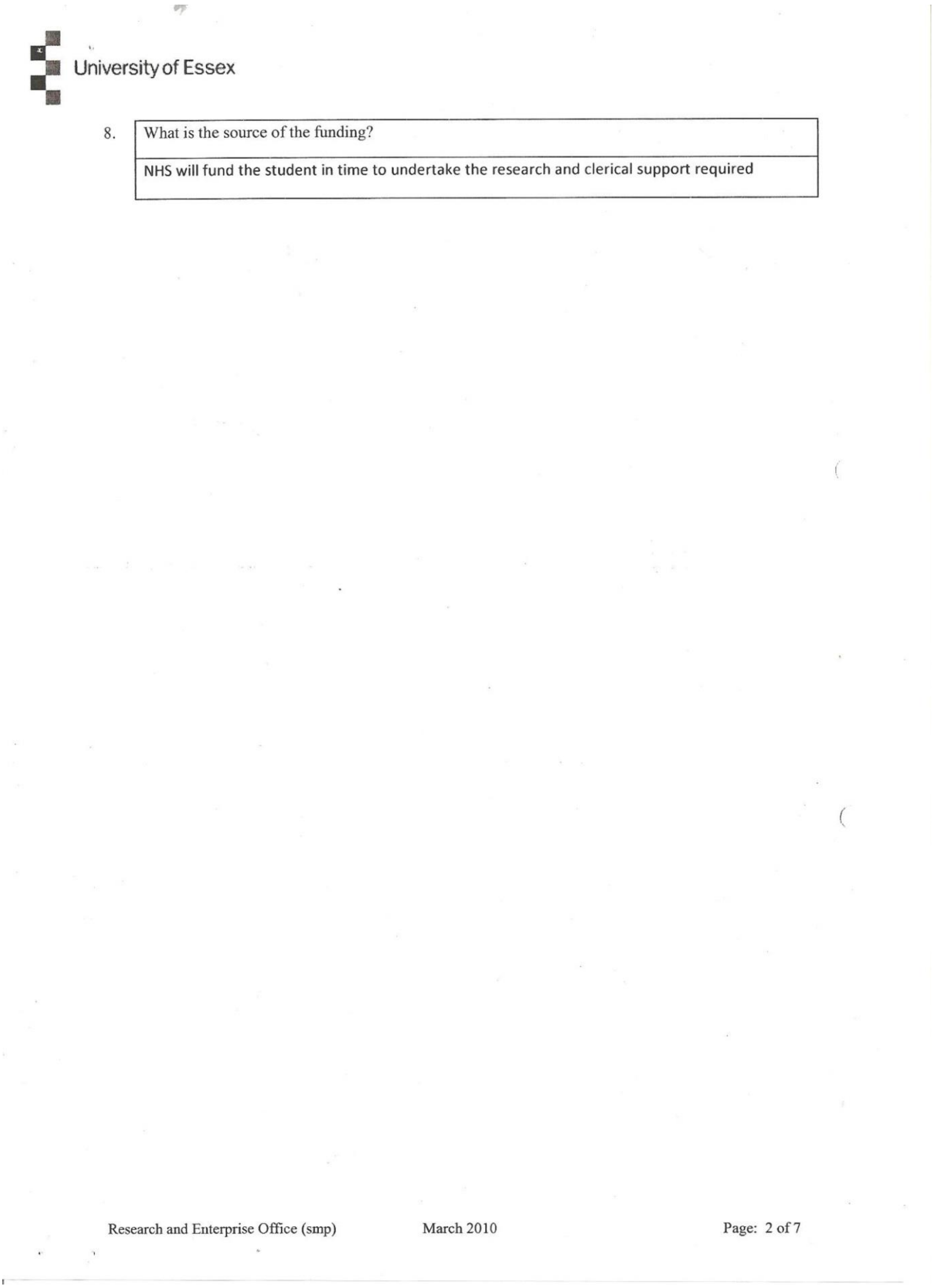
3. This Project is: ☐ Staff Research Project √ ☐ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Kathie Clibbens	
Dr Gill Green	Health& Human Sciences

5. **Proposed start date**: March 2012
6. **Probable duration**: 2 years

7. Will this project be externally funded? Yes √ ☐ / No ☐
If Yes,



University of Essex

8.	What is the source of the funding?
	NHS will fund the student in time to undertake the research and clerical support required

9. If external approval for this research has been given, then only this cover sheet needs to be submitted

External ethics approval obtained (attach evidence of approval) Yes ☐/ No √ ☐

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): ....CClibbens........

Name(s) in block capitals: ....Kathie Clibbens........

Date: ...March 2012........

Supervisor's recommendation (Student Projects only):

I recommend that this project falls under Annex B / ~~should be referred to the FEC~~ (delete as appropriate).

Supervisor's signature: ....

Outcome:

The Departmental Director of Research (DoR) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the FEC ☑

This application is referred to the FEC because it does not fall under Annex B ☐

This application is referred to the FEC because it requires independent scrutiny ☐

Signature(s): ....

Name(s) in block capitals: ....WAYNE Wilson........

Department: ....HHS........

Date: ....23/5/12........

The application has been approved by the FEC ☐

The application has not been approved by the FEC ☐

The application is referred to the University Ethics Committee ☐

Signature(s): ....

Name(s) in block capitals: ....

Faculty: ....

Date: ....

Details of the Project

1. **Brief outline of project** (This should include the purpose or objectives of the research, brief justification, and a summary of methods. It should be approx. 150 words in everyday language that is free from jargon).

This study will be undertaken using qualitative methods (Action Research) and will have the approval of the University Ethics committee. The aim is to report on and understand if the change to a Clinical Network method of working has had either positive or negative effects as judged by the professional themselves. Networks are gaining in importance in the new NHS and the l is the first of its kind within Safeguarding children. The study will look at the experiences of the Designated Doctors and Nurses within listen to their views, attitudes, experiences and expectations of the change, before the inception of during its establishment phase and then one year after.

Participant Details

2. Will the research involve human participants? (indicate as appropriate)

Yes √ ☐ No ☐

3. Who are they and how will they be recruited? (If any recruiting materials are to be used, e.g. advertisement or letter of invitation, please provide copies).

The target participants are Designated Doctors and Nurses in posts within I he clinicians will be made aware of the opportunity to take part via the current Professionals meetings where Information Participation leaflets will be available; these describe how to get more information and about getting involved. All participants will be recruited by volunteering and no detrimental effects will arise from non-participation.

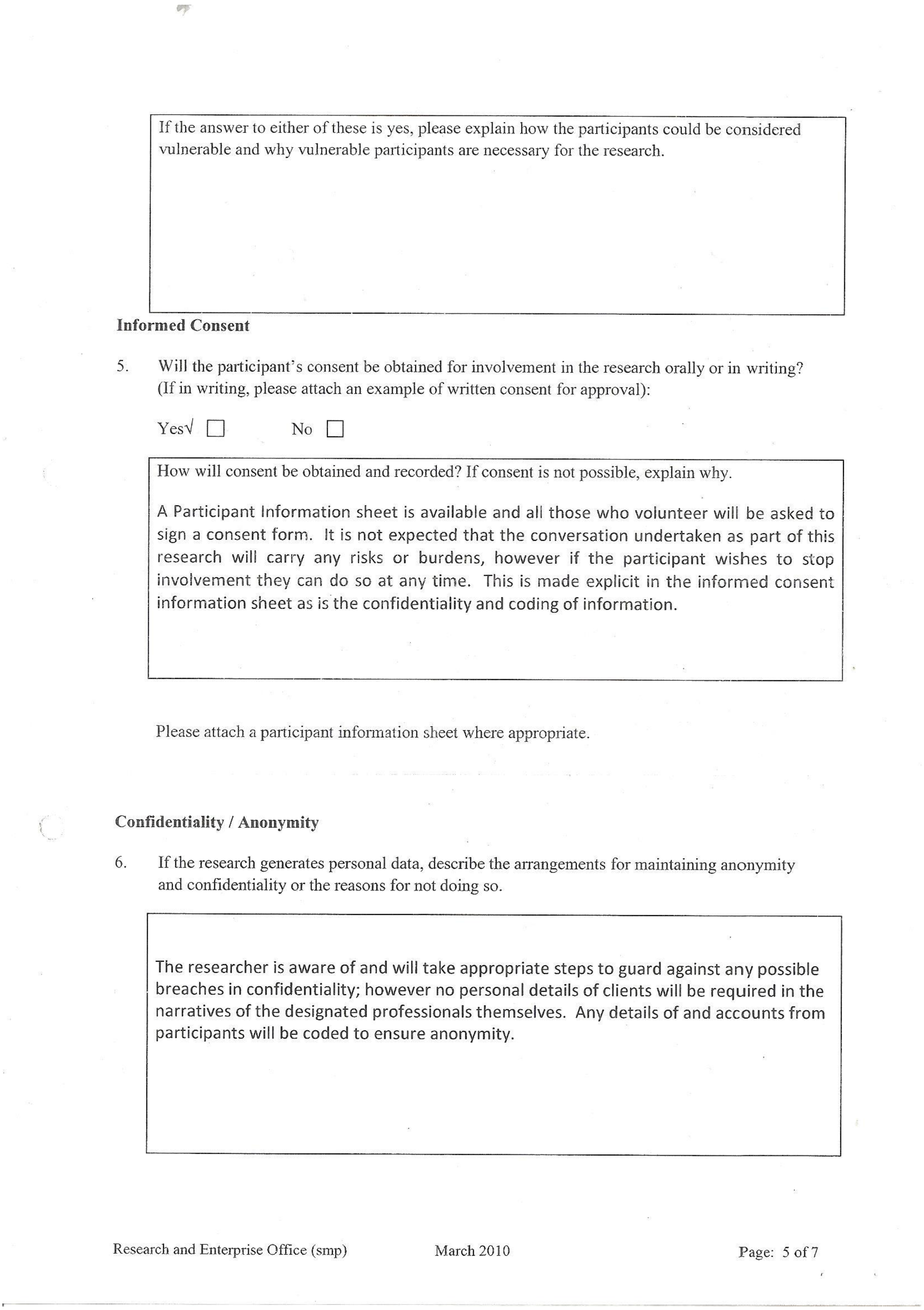
Will participants be paid or reimbursed?

There is no separate payment attached to participation, however agreement with the NHS employers has accounted for their participation to be within their working time.

4. Could participants be considered:

(a) to be vulnerable (e.g. children, mentally-ill)? Yes ☐/ No√ ☐

(b) to feel obliged to take part in the research? Yes ☐/ No√ ☐



If the answer to either of these is yes, please explain how the participants could be considered vulnerable and why vulnerable participants are necessary for the research.

Informed Consent

5. Will the participant's consent be obtained for involvement in the research orally or in writing? (If in writing, please attach an example of written consent for approval):

Yes√ ☐ No ☐

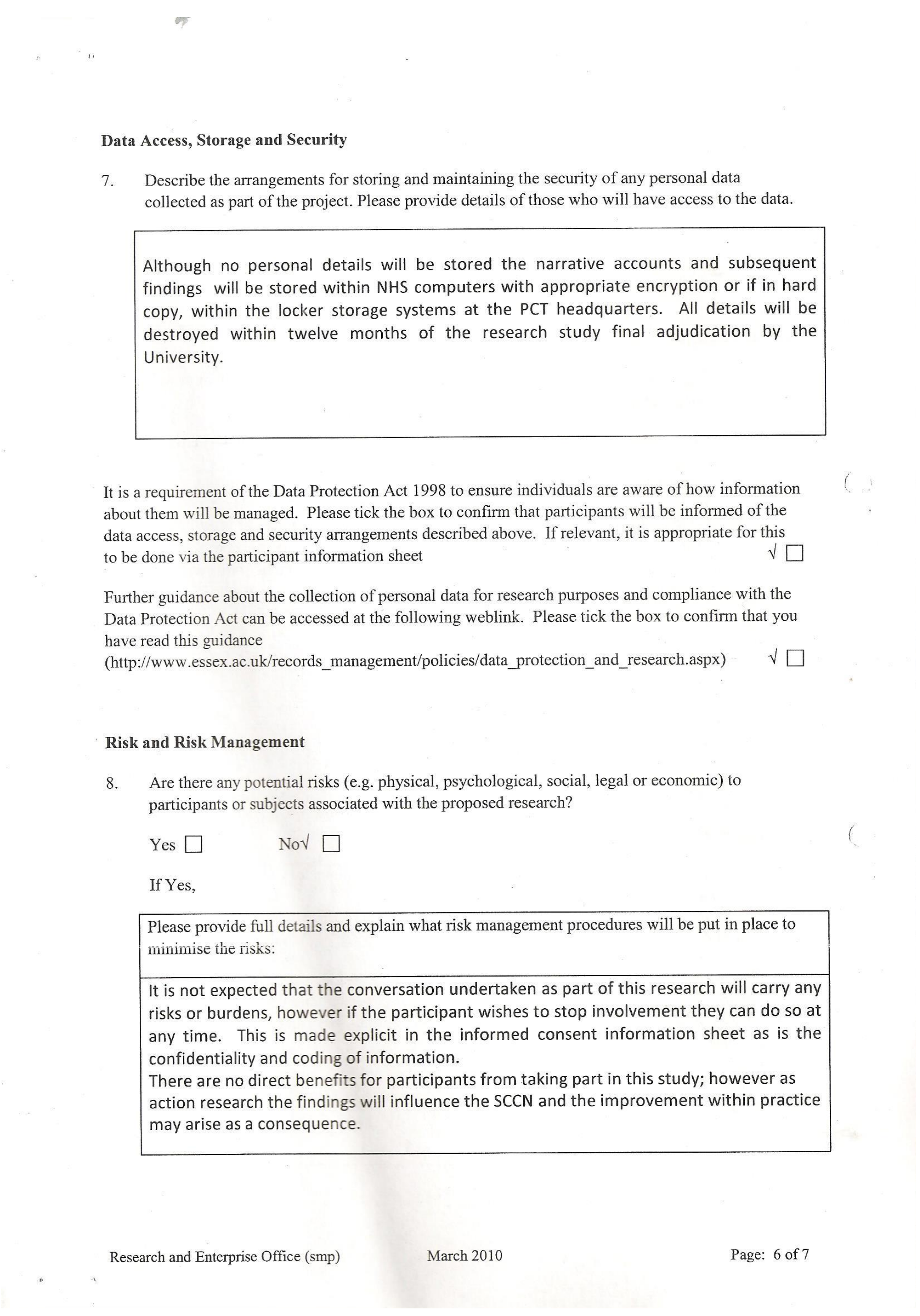
How will consent be obtained and recorded? If consent is not possible, explain why. A Participant Information sheet is available and all those who volunteer will be asked to sign a consent form. It is not expected that the conversation undertaken as part of this research will carry any risks or burdens, however if the participant wishes to stop involvement they can do so at any time. This is made explicit in the informed consent information sheet as is the confidentiality and coding of information.

Please attach a participant information sheet where appropriate.

Confidentiality / Anonymity

6. If the research generates personal data, describe the arrangements for maintaining anonymity and confidentiality or the reasons for not doing so.

The researcher is aware of and will take appropriate steps to guard against any possible breaches in confidentiality; however no personal details of clients will be required in the narratives of the designated professionals themselves. Any details of and accounts from participants will be coded to ensure anonymity.



Data Access, Storage and Security

7. Describe the arrangements for storing and maintaining the security of any personal data collected as part of the project. Please provide details of those who will have access to the data.

Although no personal details will be stored the narrative accounts and subsequent findings will be stored within NHS computers with appropriate encryption or if in hard copy, within the locker storage systems at the PCT headquarters. All details will be destroyed within twelve months of the research study final adjudication by the University.

It is a requirement of the Data Protection Act 1998 to ensure individuals are aware of how information about them will be managed. Please tick the box to confirm that participants will be informed of the data access, storage and security arrangements described above. If relevant, it is appropriate for this to be done via the participant information sheet √ ☐

Further guidance about the collection of personal data for research purposes and compliance with the Data Protection Act can be accessed at the following weblink. Please tick the box to confirm that you have read this guidance (http://www.essex.ac.uk/records_management/policies/data_protection_and_research.aspx) √ ☐

Risk and Risk Management

8. Are there any potential risks (e.g. physical, psychological, social, legal or economic) to participants or subjects associated with the proposed research?

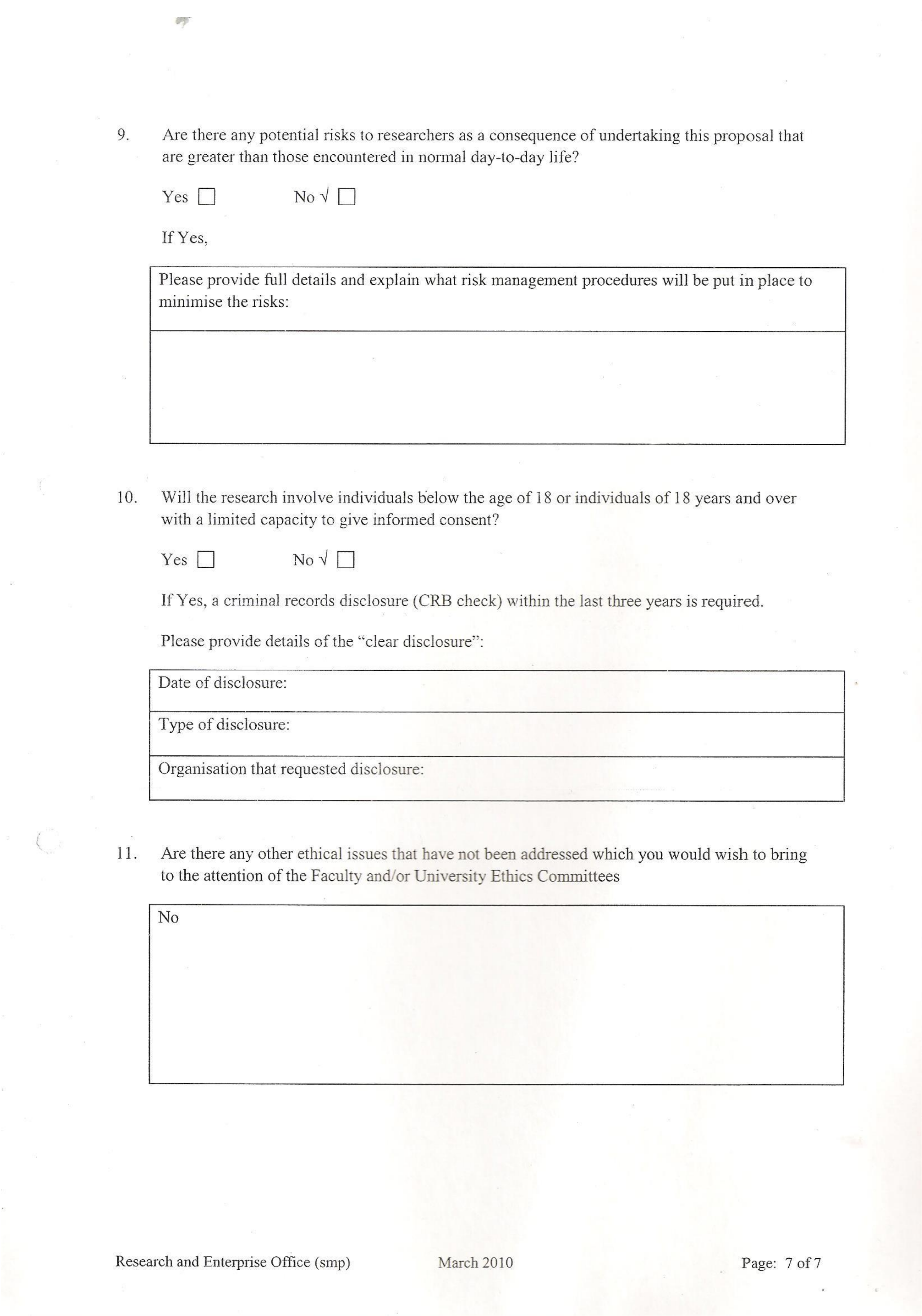
Yes ☐ No√ ☐

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:

It is not expected that the conversation undertaken as part of this research will carry any risks or burdens, however if the participant wishes to stop involvement they can do so at any time. This is made explicit in the informed consent information sheet as is the confidentiality and coding of information.

There are no direct benefits for participants from taking part in this study; however as action research the findings will influence the SCCN and the improvement within practice may arise as a consequence.



9. Are there any potential risks to researchers as a consequence of undertaking this proposal that are greater than those encountered in normal day-to-day life?

Yes ☐ No √ ☐

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:

10. Will the research involve individuals below the age of 18 or individuals of 18 years and over with a limited capacity to give informed consent?

Yes ☐ No √ ☐

If Yes, a criminal records disclosure (CRB check) within the last three years is required.

Please provide details of the "clear disclosure":

Date of disclosure:
Type of disclosure:
Organisation that requested disclosure:

11. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of the Faculty and/or University Ethics Committees

No

APPENDIX 7

NHS

18 May 2012

Mrs Kathleen M Clibbens

Dear Mrs Clibbens,

RE: Safeguarding Children Clinical Network

Project Reference Number	NP2012-003
NRES Reference Number	
Research Ethics Committee Approval Letters	Not applicable
Sponsor	University of Essex
Approved Research Site	NHS

This letter is issued on behalf of and I am pleased to confirm that the above study (defined by those documents listed above) now has permission to proceed at the above site.

Please note that this permission only relates to . If your research involves other organisations then you are recommended to contact them to find out if you require their permission.

The responsibilities for Chief Investigator, Principal Investigator and other researchers are described in the Research Governance Framework for Health and Social Care. Conditions specific to are given overleaf.

Very best wishes for your study, and please do not hesitate to contact me for any assistance during the project.

Yours sincerely,

RM&G Facilitator

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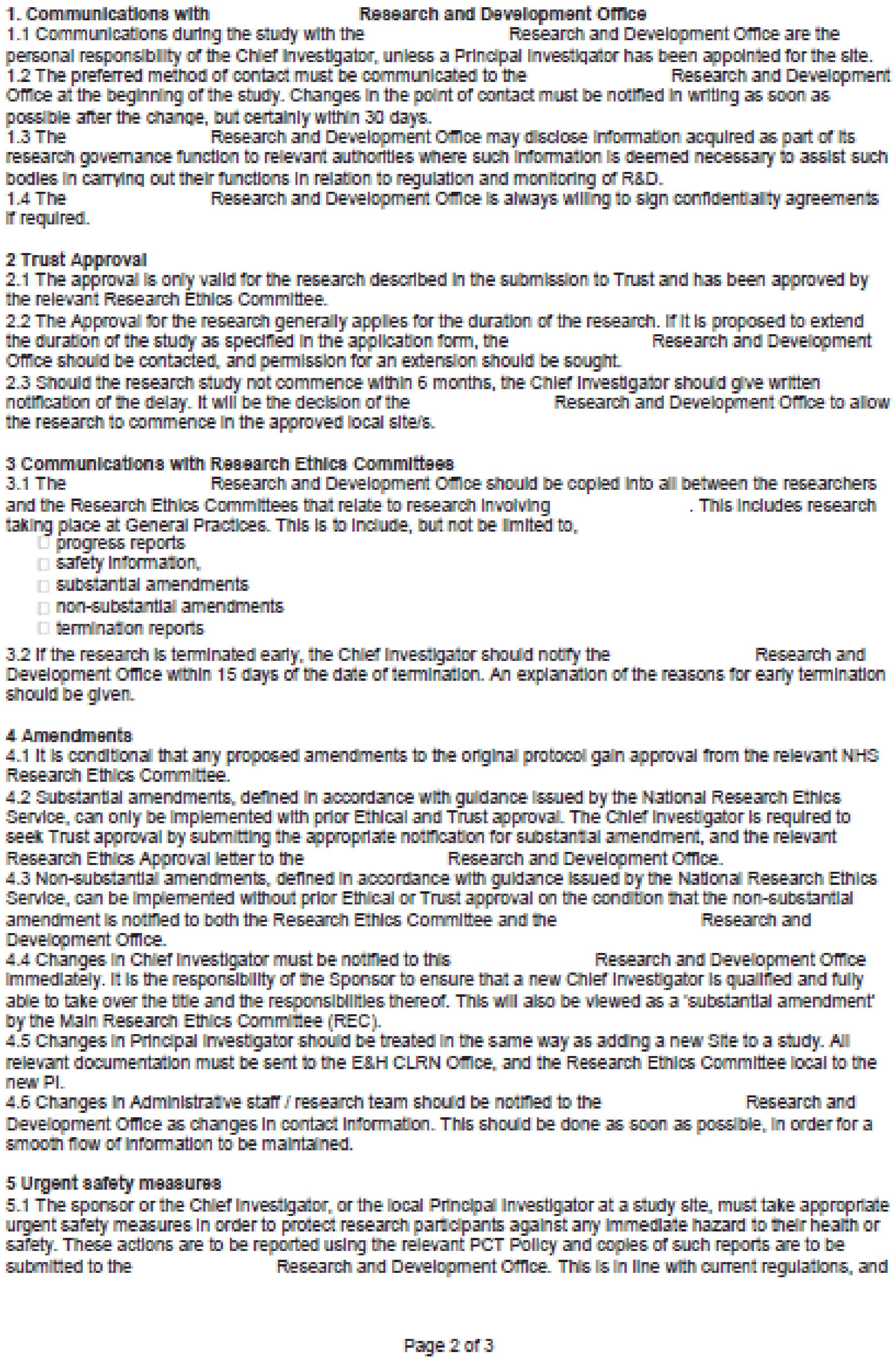

1. Communications with Research and Development Office

1.1 Communications during the study with the Research and Development Office are the personal responsibility of the Chief Investigator, unless a Principal Investigator has been appointed for the site.

1.2 The preferred method of contact must be communicated to the Research and Development Office at the beginning of the study. Changes in the point of contact must be notified in writing as soon as possible after the change, but certainly within 30 days.

1.3 The Research and Development Office may disclose information acquired as part of its research governance function to relevant authorities where such information is deemed necessary to assist such bodies in carrying out their functions in relation to regulation and monitoring of R&D.

1.4 The Research and Development Office is always willing to sign confidentiality agreements if required.

2 Trust Approval

2.1 The approval is only valid for the research described in the submission to Trust and has been approved by the relevant Research Ethics Committee.

2.2 The Approval for the research generally applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Research and Development Office should be contacted, and permission for an extension should be sought.

2.3 Should the research study not commence within 6 months, the Chief Investigator should give written notification of the delay. It will be the decision of the Research and Development Office to allow the research to commence in the approved local site/s.

3 Communications with Research Ethics Committees

3.1 The Research and Development Office should be copied into all between the researchers and the Research Ethics Committees that relate to research involving . This includes research taking place at General Practices. This is to include, but not be limited to,

- ☐ progress reports
- ☐ safety information,
- ☐ substantial amendments
- ☐ non-substantial amendments
- ☐ termination reports

3.2 If the research is terminated early, the Chief Investigator should notify the Research and Development Office within 15 days of the date of termination. An explanation of the reasons for early termination should be given.

4 Amendments

4.1 It is conditional that any proposed amendments to the original protocol gain approval from the relevant NHS Research Ethics Committee.

4.2 Substantial amendments, defined in accordance with guidance issued by the National Research Ethics Service, can only be implemented with prior Ethical and Trust approval. The Chief Investigator is required to seek Trust approval by submitting the appropriate notification for substantial amendment, and the relevant Research Ethics Approval letter to the Research and Development Office.

4.3 Non-substantial amendments, defined in accordance with guidance issued by the National Research Ethics Service, can be implemented without prior Ethical or Trust approval on the condition that the non-substantial amendment is notified to both the Research Ethics Committee and the Research and Development Office.

4.4 Changes in Chief Investigator must be notified to this Research and Development Office immediately. It is the responsibility of the Sponsor to ensure that a new Chief Investigator is qualified and fully able to take over the title and the responsibilities thereof. This will also be viewed as a 'substantial amendment' by the Main Research Ethics Committee (REC).

4.5 Changes in Principal Investigator should be treated in the same way as adding a new Site to a study. All relevant documentation must be sent to the E&H CLRN Office, and the Research Ethics Committee local to the new PI.

4.6 Changes in Administrative staff / research team should be notified to the Research and Development Office as changes in contact information. This should be done as soon as possible, in order for a smooth flow of information to be maintained.

5 Urgent safety measures

5.1 The sponsor or the Chief Investigator, or the local Principal Investigator at a study site, must take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. These actions are to be reported using the relevant PCT Policy and copies of such reports are to be submitted to the Research and Development Office. This is in line with current regulations, and

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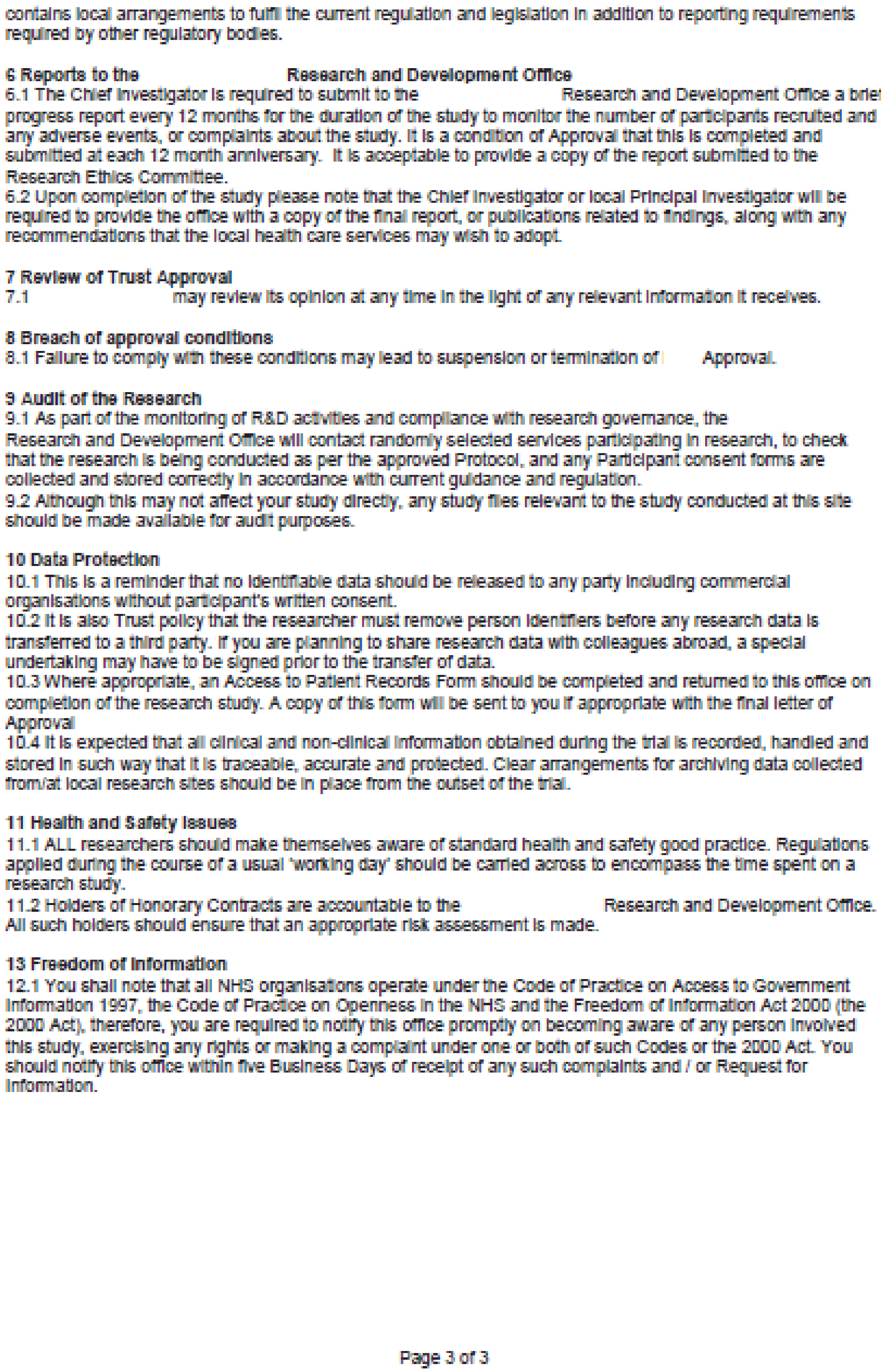


contains local arrangements to fulfil the current regulation and legislation in addition to reporting requirements required by other regulatory bodies.

6 Reports to the Research and Development Office
6.1 The Chief Investigator is required to submit to the Research and Development Office a brie progress report every 12 months for the duration of the study to monitor the number of participants recruited and any adverse events, or complaints about the study. It is a condition of Approval that this is completed and submitted at each 12 month anniversary. It is acceptable to provide a copy of the report submitted to the Research Ethics Committee.
6.2 Upon completion of the study please note that the Chief Investigator or local Principal Investigator will be required to provide the office with a copy of the final report, or publications related to findings, along with any recommendations that the local health care services may wish to adopt.

7 Review of Trust Approval
7.1 may review its opinion at any time in the light of any relevant information it receives.

8 Breach of approval conditions
8.1 Failure to comply with these conditions may lead to suspension or termination of Approval.

9 Audit of the Research
9.1 As part of the monitoring of R&D activities and compliance with research governance, the Research and Development Office will contact randomly selected services participating in research, to check that the research is being conducted as per the approved Protocol, and any Participant consent forms are collected and stored correctly in accordance with current guidance and regulation.
9.2 Although this may not affect your study directly, any study files relevant to the study conducted at this site should be made available for audit purposes.

10 Data Protection
10.1 This is a reminder that no identifiable data should be released to any party including commercial organisations without participant's written consent.
10.2 It is also Trust policy that the researcher must remove person identifiers before any research data is transferred to a third party. If you are planning to share research data with colleagues abroad, a special undertaking may have to be signed prior to the transfer of data.
10.3 Where appropriate, an Access to Patient Records Form should be completed and returned to this office on completion of the research study. A copy of this form will be sent to you if appropriate with the final letter of Approval
10.4 It is expected that all clinical and non-clinical information obtained during the trial is recorded, handled and stored in such way that it is traceable, accurate and protected. Clear arrangements for archiving data collected from/at local research sites should be in place from the outset of the trial.

11 Health and Safety Issues
11.1 ALL researchers should make themselves aware of standard health and safety good practice. Regulations applied during the course of a usual 'working day' should be carried across to encompass the time spent on a research study.
11.2 Holders of Honorary Contracts are accountable to the Research and Development Office. All such holders should ensure that an appropriate risk assessment is made.

13 Freedom of Information
12.1 You shall note that all NHS organisations operate under the Code of Practice on Access to Government Information 1997, the Code of Practice on Openness in the NHS and the Freedom of Information Act 2000 (the 2000 Act), therefore, you are required to notify this office promptly on becoming aware of any person involved this study, exercising any rights or making a complaint under one or both of such Codes or the 2000 Act. You should notify this office within five Business Days of receipt of any such complaints and / or Request for Information.

Example of initial codes from Phase one

Timely advance	(X12) The idea seemed to fit the climate *It was a long overdue development* *Changes in NHS who knows who's responsible for what* Some did work collaborating, other pulled away *Share the increasing workload across specialisms would be cost effective and give a united voice* One Designate voice *Large job only one post to do it all as Safeguarding now being seen as everyone business* Systems way of working *Safeguarding needs to be in every fibre of the Organisation* There will be no hiding place for slackers	(X25) Need for an easy way of working to overcome barriers Free of outside influence for either good or bad LAC profile *Felt time was right to spread good practice* Impetus to recent advances	(X46) difficult having an AD in Safeguarding Streamline one set of information to give to providers' other agencies Clarity and present for commissioners Raised profile for LAC *Need a team identity to deliver across wide range of services* Professional development *Strengthened ties the medics and GPs* *Feels it addressed the enormity of the job* *Needs to be leadership for individuals and for the topic* *Need to spread the workload* *Everyone gets to do the high profile and the backroom work*	(X39) No leads out there Local identity will encourage better information sharing *Hard to know what to advise the Trust when these things are only just hitting the consciousness.*	(X65) *The Health environment is getting ever more 'bitty'* *Having supervision and peer review within a community can implement change* IT doesn't fit, and can't move things forward ------------------------------------- Feedback CP -"let's get on with the change" LAC- Pull of CP on the mixed roles, so losing focus on LAC Decrease in LAC capacity Model would mean change from provision of services to straight forward commissioning Lack of admin to LAC Des- Strongly in support Needs clarity of job plans; will it mean more regularity to the hours needed What will it do for pay ALL- want expertise to be developed
Problems in the present	(X12) *working in silos not getting anywhere* Changes in NHS financial climate *Lots of effort being duplicated by so many* *amendments to everything (for localism) nothing got advanced* Some collaborate, other pulled away	Started working differently when spilt with providers, slows things down keep it local Provider split erected barriers Lack of admin support *Lack of training/courses for CP specialists at level 4/5*	AD role had caused friction with providers and stopped Des looking to colleagues Responsibilities was not succinct or clear Roles blurred and ended up no-one doing it *There conflict of*	*Marginalising certain people* *Skills of CAMHS made to feel like outsiders* Children's trusts stopping lost some key relationships Blame culture	*Lonely job - don't meet with others in the same field* Feels like there is little achieved striving on your own It is such a large patch and all the other services work differently *Raising concerns with SC doesn't change anything*

	Deficits in the staffing levels *Designated Doctors just not linked in to the Designated workload* Multi agency – much more difficult as could only speak for a selection of 'Trusts' *sometimes(SC) had time to consult with us but mostly not then decisions taken not supported internally within other health groups* No place to learn what the current thinking is No place to check out alternative view *Having 5 different PCTs to convince to take anything forward* *Jobs just to big* *Inspections taking up time sorting the wrong priorities* Development work took so much time due to lack of staff and size of problem -- Feedback (X17) Pushing up standards in providers Needs to have a wider good practice *System needs better audit and data so the management of data can mean something, but what will do that* *How can resources be used effectively if all pulling in own direction* Needs central lynchpin *Ability to keep up-to-date by having a reduced but more intensive portfolio* Foster care training new dev. *New guidance needs more manpower-together can then ensure that we're fit to deliver, and have the time to write,*	*Lack of IT skills* Systmone blessing and curse *Up skilling of the Named GP role, how else does one person get to know so much stuff* *Knowledge needs to be in real time to make a difference* Lack of knowledge of how to Operationalise knowledge Problem solve Assessments when audience uses them for different things *No mandate for RCPCH toolkit so how to implement* Users voice not being sought Ability to pass on if can't be dealt with either because of time or skill *Worry on own ability to deal with the situation* Information flooding/overload What do you do with Domestic abuse. Never knowing the full picture Referrals – never followed up Response from Social care – especially case conferences Knock back for SC	*information given within and outside* Lack of clarity actually stopped issues being brought to the notice of the designate *Not having functioning team worsens the lack of LAC commissioning* Relationships with GP are developing Supervision functions but has needed a lot of work *Lack of development opportunities, where do we at this level go?* *loss relationship with Dr & GP's* No ownership with the delivered of actions *IT systems inadequate with Information flows … being good but not fully formed. Being separate (from providers) is then a barrier* Lack of admin don't know how best to use what is available Strayed onto Adult Safeguarding resources taken *Never feeling I had handle on all the job* Lack of emphasis on CDR *an elite club just you* No one action plan	*No influence on the wider agenda* Where does the information flow to and what does it influence? Lack of resources for children Links with in/pt facilities Who speaks up for therapeutic placements interventions *Missing things like Substance misusing parents or Complex families* Specialists are needed to inform this CSA Breaking intergenerational abuse Lack of information sharing Who performance manages the service Safeguarding seen as poor relation *Working in silos* *Lack of joint working with LAC as linked only by a commissioners' contract*	*Most of the responsibility lies with other agencies so can't make things change or own anything* Appears a simple task but having done a Needs still can't change things IT doesn't fit, holding things back *in a double silo, within Health as an agency and then within a part of health within health* Auditing doesn't reach the level in which changes would be made, no influence *Impact for county work on LAC so small, doesn't impact at all* No one to follow through Resource shortages Access to individuals across wide patch, *One person has no 'teeth'* *Trying to get thru to commissioners very difficult they speak a different language* *IT needs functionality Crossing providers' boundaries difficult* Information flows from CAMHS *Never knowing the complete health picture* Things happen unseen by professionals but looking to you to take a lead. Disjointed *No one carrying the can*

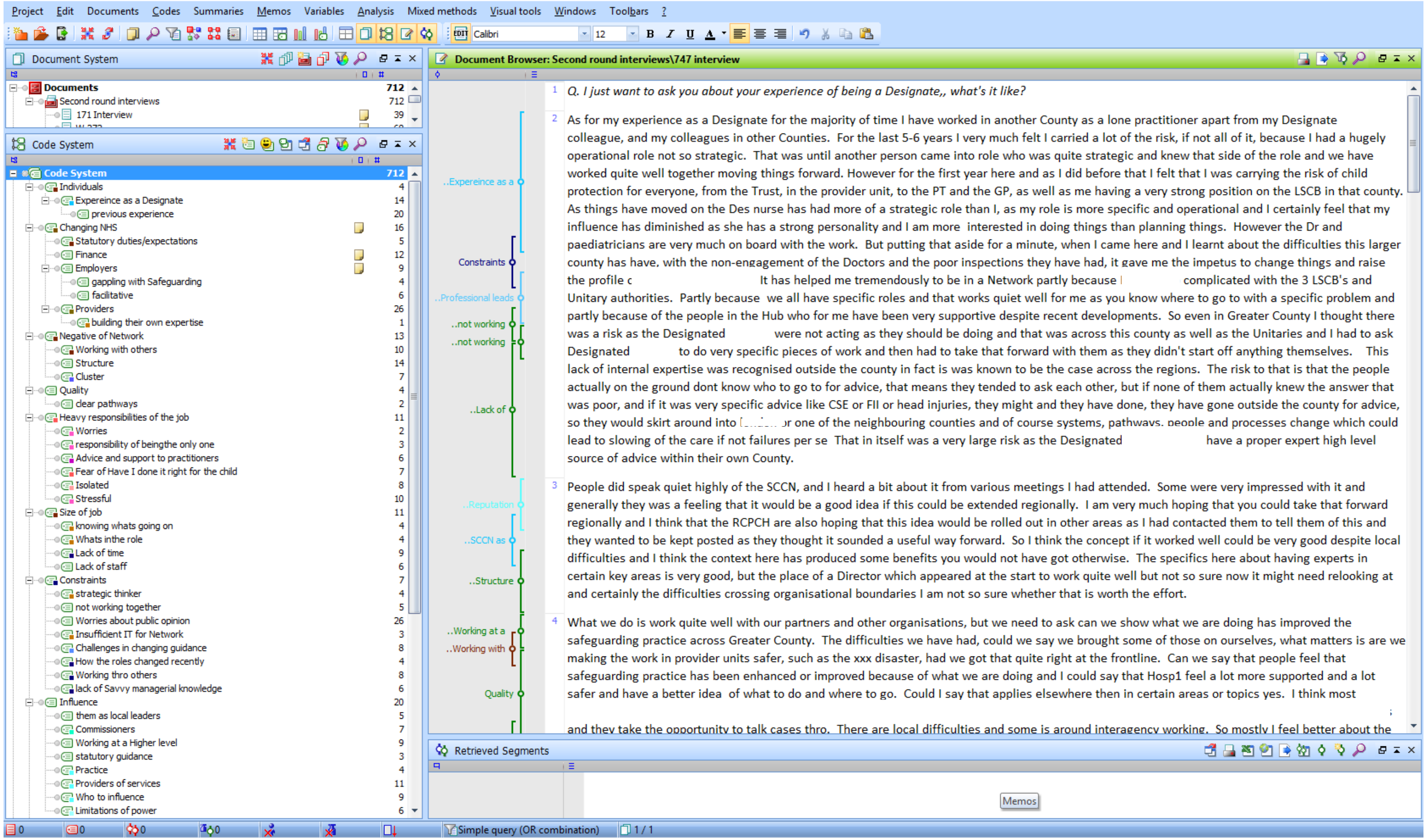
Example of framework of themes and categories from Phase one

Theme	Category	Sub-category	Code
Timely Drivers for change	Safeguarding is now a bigger issue	Responding to changes in thinking on Safeguarding	Systems way of working Streamline one set of information to give to other agencies The idea seemed to fit the climate Impetus to recent advances
		Need to impact on many parts	Safeguarding now being seen as everyone business Safeguarding being in every fibre of the Organisation Need to spread the workload Need a team identity to deliver across wide range of services Need for an easy way of working to overcome barriers SARC needs input
		LAC profile	LAC profile bigger Raised profile for LAC New role of LAC profs Need to work with foster carers & set standards
		Health as leaders in Safeguarding	Free of outside influence for either good or bad Safeguarding being in every fibre of the Organisation
		New areas of work	SARC LAC foster carers Work with users themselves to drive up standards
Timely Drivers for change	Too big a job for one	Collaborative working	Some did work collaboratively, (already there) Felt time was right to spread good practice Need a team identity to deliver across wide range of services Strengthened ties the medics and GP's a united voice
		Increase in what has to be covered	Share the increasing workload across specialism's The Health environment is getting ever more 'bitty' Need to spread the workload Everyone gets to do the high profile and the backroom work Development work took so much time due to lack of staff and size of problem
		Demand for expertise increased	Need to be seen as an expert Large job only one post to do it all There can be no hiding place for slackers Professional development required Felt it addressed the enormity of the job Number of SCR/IMR's New role of LAC
Timely Drivers for change	Direction needed		Needs to be leadership for individuals and for the topic One Designate voice Having supervision and peer review within a community that then can implement change No leads out there a united voice
Timely Drivers for	External forces	Changes in the NHS	Changes in NHS (Drive to be) cost effective The Health environment is getting ever more 'bitty'

change			Disjointed
		IT inadequacies	IT doesn't fit, and can't move things forward
		Need for performance data	Streamline one set of information to give to other agencies Better audit + management of data which means something
Timely Drivers for change	Raise the profile	Within health commissioning	Safeguarding now being seen as everyone business Safeguarding being in every fibre of the Organisation Felt time was right to spread good practice Clarity and presence for commissioners Trying to get thru to commissioners very difficult they speak a different language Better audit + management of data which means something SHA- Very supportive
		of Health with partners	Local identity will encourage better information sharing Streamline one set of information to give to providers' other agencies Some did work collaborating, other pulled away
Problems in the Present	Divided by perceived/actual boundaries	Organisational internal	Working in silos not getting anywhere Amendments to everything (for localism) nothing advanced Having 5 different PCTs to convince to take anything forward Started working differently when spilt with providers Provider split erected barriers Role confusion stopped Des looking to colleagues Lack of clarity actually stopped issues being brought to the notice of the designate Being separate is then a barrier Links with in/pt. facilities Working in silos Lack of joint working with LAC in a double silo, within Health as an agency and then within a part of health within health Trying to get thru to commissioners very difficult they speak a different language Crossing providers' boundaries How can resources be used effectively if all pulling in own direction Not supported internally within other health groups Not getting the benefit of taking actions across wider patch Access to individuals across such a wide patch, not knowing who you are Trying to get thru to commissioners very difficult they speak a different language Crossing providers' boundaries Information flows from CAMHS

		Organisational external	Multi agency – much more difficult as could only speak for a selection of 'Trusts' They (SC) sometimes had time to consult with us but mostly not then decisions taken Assessments when audience uses them for different things Ability to pass on if can't be dealt with either for time or ability Children's trusts stopping lost some key relationships Raising concerns with SC doesn't change anything in a double silo, Health agency then within a part of health Linked only by a commissioners' contract Users voice not being sought How to be a leader in the Provider units Acceptance of supervision by some Social care drowns practitioners voice Feel despite place of the ESCB the trust feels disconnected
		Professional	Loss relationship with Dr & GP's Designated Doctors just not linked in Relationships with GP are developing Marginalising certain people/ skills CAMHS feels outsiders
Problems in the Present	Working practices	Repetition of effort due to multiple organisations	Assessments when audience uses them for different things Amendments to everything (for localism) nothing got advanced Roles blurred and ended up no-one doing it
		Accountability & Responsibility	Responsibilities was not succinct or clear No one carrying the can No ownership with the delivered of actions Blame culture No one accountable
		Open & Sharing culture	Lack of information sharing Conflict of information given within and outwith Information flows here been good but not fully formed Where does information flow to and what does it influence Information flows from CAMHS Not supported internally within other health groups
		New demands	Transferable training at 1,2,3 for CP and LAC Transition
Problems in the Present	The changing organisational environment	Macro	Changes in NHS Financial climate
		Micro	Strayed onto Adult Safeguarding took resources away Jobs and people being moved without consultation Safeguarding seen as poor relation Some bosses needed to control (micro manage)

Example of early coding in Phase two



Documents			712
	Second round interviews		712
		171 Interview	39

Code System			712
	Individuals		4
	Expereince as a Designate		14
		previous experience	20
	Changing NHS		16
	Statutory duties/expectations		5
	Finance		12
	Employers		9
		gappling with Safeguarding	4
		facilitative	6
	Providers		26
		building their own expertise	1
	Negative of Network		13
	Working with others		10
	Structure		14
	Cluster		7
	Quality		4
	clear pathways		2
	Heavy responsibilities of the job		11
	Worries		2
	responsibility of beingthe only one		3
	Advice and support to practitioners		6
	Fear of Have I done it right for the child		7
	Isolated		8
	Stressful		10
	Size of job		11
	knowing whats going on		4
	Whats inthe role		4
	Lack of time		9
	Lack of staff		6
	Constraints		7
	strategic thinker		4
	not working together		5
	Worries about public opinion		26
	Insufficient IT for Network		3
	Challenges in changing guidance		8
	How the roles changed recently		4
	Working thro others		8
	lack of Savvy managerial knowledge		6
	Influence		20
	them as local leaders		5
	Commissioners		7
	Working at a Higher level		9
	statutory guidance		3
	Practice		4
	Providers of services		11
	Who to influence		9
	Limitations of power		6

1 *Q. I just want to ask you about your experience of being a Designate,, what's it like?*

2 As for my experience as a Designate for the majority of time I have worked in another County as a lone practitioner apart from my Designate colleague, and my colleagues in other Counties. For the last 5-6 years I very much felt I carried a lot of the risk, if not all of it, because I had a hugely operational role not so strategic. That was until another person came into role who was quite strategic and knew that side of the role and we have worked quite well together moving things forward. However for the first year here and as I did before that I felt that I was carrying the risk of child protection for everyone, from the Trust, in the provider unit, to the PT and the GP, as well as me having a very strong position on the LSCB in that county. As things have moved on the Des nurse has had more of a strategic role than I, as my role is more specific and operational and I certainly feel that my influence has diminished as she has a strong personality and I am more interested in doing things than planning things. However the Dr and paediatricians are very much on board with the work. But putting that aside for a minute, when I came here and I learnt about the difficulties this larger county has have, with the non-engagement of the Doctors and the poor inspections they have had, it gave me the impetus to change things and raise the profile c [redacted] It has helped me tremendously to be in a Network partly because I [redacted] complicated with the 3 LSCB's and Unitary authorities. Partly because we all have specific roles and that works quiet well for me as you know where to go to with a specific problem and partly because of the people in the Hub who for me have been very supportive despite recent developments. So even in Greater County I thought there was a risk as the Designated [redacted] were not acting as they should be doing and that was across this county as well as the Unitaries and I had to ask Designated [redacted] to do very specific pieces of work and then had to take that forward with them as they didn't start off anything themselves. This lack of internal expertise was recognised outside the county in fact is was known to be the case across the regions. The risk to that is that the people actually on the ground dont know who to go to for advice, that means they tended to ask each other, but if none of them actually knew the answer that was poor, and if it was very specific advice like CSE or FII or head injuries, they might and they have done, they have gone outside the county for advice, so they would skirt around into [redacted] or one of the neighbouring counties and of course systems, pathways, people and processes change which could lead to slowing of the care if not failures per se That in itself was a very large risk as the Designated [redacted] have a proper expert high level source of advice within their own County.

3 People did speak quiet highly of the SCCN, and I heard a bit about it from various meetings I had attended. Some were very impressed with it and generally they was a feeling that it would be a good idea if this could be extended regionally. I am very much hoping that you could take that forward regionally and I think that the RCPCH are also hoping that this idea would be rolled out in other areas as I had contacted them to tell them of this and they wanted to be kept posted as they thought it sounded a useful way forward. So I think the concept if it worked well could be very good despite local difficulties and I think the context here has produced some benefits you would not have got otherwise. The specifics here about having experts in certain key areas is very good, but the place of a Director which appeared at the start to work quite well but not so sure now it might need relooking at and certainly the difficulties crossing organisational boundaries I am not so sure whether that is worth the effort.

4 What we do is work quite well with our partners and other organisations, but we need to ask can we show what we are doing has improved the safeguarding practice across Greater County. The difficulties we have had, could we say we brought some of those on ourselves, what matters is are we making the work in provider units safer, such as the xxx disaster, had we got that quite right at the frontline. Can we say that people feel that safeguarding practice has been enhanced or improved because of what we are doing and I could say that Hosp1 feel a lot more supported and a lot safer and have a better idea of what to do and where to go. Could I say that applies elsewhere then in certain areas or topics yes. I think most

and they take the opportunity to talk cases thro. There are local difficulties and some is around interagency working. So mostly I feel better about the

APPENDIX 11

Example of emerging categories in Phase two

Code-ID	Position	Parent code	Code	All coded segments	All coded segments %	Documents
70	1		Negative of Network	5	0.95	1
67	2		Quality	2	0.38	1
68	3	Quality	clear pathways	2	0.38	1
58	4		Experience as a Designate	7	1.33	4
71	5	Experience as a Designate	previous experience	9	1.71	1
54	6		Drivers to practice	7	1.33	2
8	7		Barriers	9	1.71	3
50	8	Barriers	Fear of change	2	0.38	1
33	9	Barriers	Insufficient IT for Network	2	0.38	2
27	10	Barriers	Providers	23	4.37	7
56	11	Barriers\Providers	building their own expertise	1	0.19	1
25	12	Barriers	NHS Changing landscape	17	3.23	6
2	13		Heavy responsibilities of the job	11	2.09	4
66	14	Heavy responsibilities of the job	Worries	2	0.38	2
65	15	Heavy responsibilities of the job	responsibility of being the only one	5	0.95	3
63	16	Heavy responsibilities of the job	Revision of the role	1	0.19	1
16	17	Heavy responsibilities of the job	Advice and support to practitioners	6	1.14	5
15	18	Heavy responsibilities of the job	Fear of Have I done it right for the child	8	1.52	5
5	19	Heavy responsibilities of the job	Isolated	8	1.52	4
10	20	Heavy responsibilities of the job	Stressful	11	2.09	5
31	21		Training others	5	0.95	2
3	22		Size of job	6	1.14	4
72	23	Size of job	strategic thinker	3	0.57	1
52	24	Size of job	knowing what's going on	3	0.57	1
44	25	Size of job	What's in the role	3	0.57	2
19	26		Constraints	5	0.95	2

57	27	Constraints	Challenges in changing guidance	7				1.33		2
53	28	Constraints	How the roles changed recently	5				0.95		3
51	29	Constraints	Communication	1				0.19		1
49	30	Constraints	Working thro others	7				1.33		4
47	31	Constraints	Lack of time	3				0.57		2
32	32	Constraints	Lack of staff	3				0.57		3
24	33	Constraints	What's lacking	1				0.19		1
20	34	Constraints	lack of Savvy managerial knowledge	6				1.14		4
17	35		Worries about public opinion	15				2.85		8
1	36		Influence	15				2.85		5
69	37	Influence	statutory guidance	2				0.38		1
43	38	Influence	Practice	4				0.76		3
42	39	Influence	Providers of services	8				1.52		4
21	40	Influence	Who to influence	6				1.14		4
9	41	Influence	Limitations of power	5				0.95		4
6	42		Cluster	7				1.33		5
40	43		Rewards of the job	4				0.76		2
36	44		LAC	18				3.42		5
12	45		Decision making	12				2.28		6
60	46	Decision making	Consensual	1				0.19		1
46	47	Decision making	outcomes	9				1.71		6

APPENDIX 12

Extract from the Interpretation matrix from Phases one and two

DATA Phase one	DATA Phase Two	Reflections and argument	Supporting literature	Overarching finding
Worry re new responsibility of GP training Doctors and nurses did not work jointly	Positive feedback and better engagement with GPs Success/ benefits of Named GP role Joint Dr and Nurse work positive for both	Expansion of Network professions has improved practice Joint work seen as beneficial by all parties Accessing previously hard to reach professionals	Scarcity of Named GP practitioners Why GPs and Dr are disengaging from Child Protection Training and support highlighted as a way to encourage Dr and GPs to participate	Network's alliances beneficial to all
Nurses fundamental need to work with frontline HVs and SNs Felt cut off from practice Did not understand how to make Safeguarding children 'real' to commissioners	Wish to work with frontline tailored to working through Named nurses Engagement when 'things went wrong' Acceptance of commissioning as the way to improve practice Learnt some of the commissioning language and KPIs	Problems will now only be seen through the scrutiny of available information which is released thorough the governance process. Difficulty in addressing new emerging issues as unless specific questions asked of the Trusts the information they supply will not identify the issues.	Reliance on engagement of practitioners Use of supervision Informatics as the way to interpret the situation	Augmented knowledge
Designated Dr remoteness from the strategic workload Embedded in acute sector	Network support them which clarified the benefits they offered positive seen in joint learning and practice Unconvinced the amount of time spent on commissioning was more beneficial to children than frontline work	The Drs were early adopters of the Network. They wanted supervision and peer review process offered. Engagement with the forums and solution seeking review process was highly regarded Majority wanted to be a reactive rather than proactive	Review of Des Dr role Intercollegiate document Ways of teaching and learning Peer review and supervision	Enhanced practice and new solutions

APPENDIX 12

Distance from providers left Nurse feeling, cut off; out of touch; starved of information; not trusted or a spy. Blamed the Named nurses for unclear or changed roles Worried providers wouldn't be honest so would not be able to change in response to SCRs	Accepted restrictions as understood needs in a competitive market Still felt mistrusted and NN relationship with not regained Wanted to be seen as helper, but also content to monitor and sanction Moved to commissioner role, but struggled with detailed	Felt being out of touch devalued their opinions 'knowledge is power and currency' Worried being theoretical, as partners closer to frontline Felt simultaneous NHS changes and Network creation supported and benefited them	Teamwork Changes in Policy documents including AAF and WT Learning and competence Action research and action learning Media concerns Sharon Shoesmith example	Indirect pressures a source of stress
The worry of the CQC inspection recommendations The need to address issued across the county Inconsistencies and differences in knowledge and expectations Unclear as to any future structures and their place in it Local fear ‘will partners like It’	Individual recommendations faded but had adopted the priorities as mainstream workload Felt 'one voice' to negotiate with had benefited health and partners Felt influence had increased Enjoyed the scrutiny role Power seen differently	Inspection had changed the expectations on Des profs and boosted the drivers of change As new people joined the 'norm' was seen as to work together, deficits in the status quo were compared with the now and not the past. Power and authority used differently	Influence of political environment Upheaval alters receptivity to change Leadership and management Supportive workplaces	Collaboration had enhanced practice
Didn't know how to be a commissioner Lack of knowledge and language Felt disadvantaged and scrutinised by the new teams in the PCTs Had no peers within PCTs to replace the contact with the frontline Denied the expertise could be in anything but frontline	Slowly work improving with commissioners Still felt disadvantaged and that their bosses didn't see them as coms- as weren't offered mainstream leadership courses Worried they still didn't excel at contract/KPI development Not use to the immediacy or level of the workload	The upheaval changed the status quo and they could no longer stay as they were. Talents they had were not needed and the ones they needed were hard to achieve The Network had the talents needed and allowed them 'breathing space' to keep on top of their work and 'behind the scenes’ develop the knowledge/skills require	Kurt Lewin 'unfreeze, frame, refreeze' NHS reforms Knowledge acquisition Experiential learning Leadership Identity and support to the person Developments in child protection work Stress at work	Changes in expectations