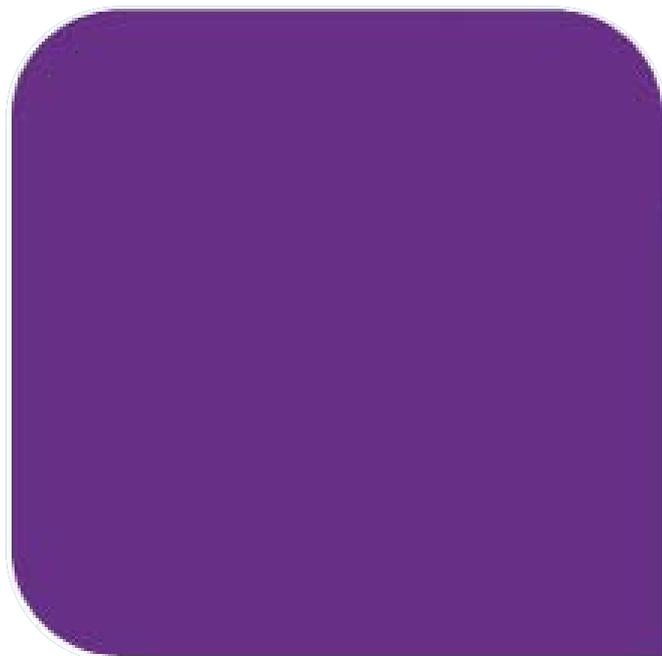


# Partnership working in child protection: improving liaison between acute paediatric and child protection services



This report looks at how acute paediatric and local authority statutory child protection services in England work together in cases of suspected child maltreatment.

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# Partnership working in child protection: improving liaison between acute paediatric and child protection services

Jane Lewis

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Written by Jane Lewis

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# Executive summary

## Introduction

- This study was carried out by the Social Care Institute for Excellence (SCIE) as part of the programme of work of the Policy Research Unit in the Health of Children, Young People and Families (CPRU), funded by the Department of Health. The views expressed are not necessarily those of the Department. The aim was to understand how acute paediatric and local authority statutory child protection services work together in cases of suspected child maltreatment. In particular, the study looks at what is viewed locally as good practice in staffing, identifying cases where child maltreatment should be considered, referring cases to social care and information-sharing, and to explore what supports interface arrangements that professionals deem most effective.
- The report draws on:
  - an online survey of acute trusts, mostly completed by Named Nurses for Child Protection, focusing on arrangements and cases within Emergency Departments (EDs). A total of 55 trusts responded (a response rate of 33%), and the response base for individual questions varied between 40 and 55.
  - 12 qualitative research case studies (10 involving the local authority and acute trust; two involving the acute trust only), which looked at joint work and both the ED and maternity service. A total of 28 interviews took place involving 29 individuals, 17 of them trust staff and 12 local authority staff. Sites selected as case studies were those where there was evidence to suggest more effective joint work. They represent, therefore, local areas with more advanced liaison arrangements.
  - a Call for Practice, based on SCIE's established 'Good Practice Framework' format, asking for examples of effective local practice: eight examples were submitted and five are summarised in this report.
- The mixed-method approach aimed to obtain data that illustrated both the broad picture of joint-working in cases of suspected child maltreatment, as well as detailed insights that could help improve practice. There are strengths and limitations inherent in the study methods. The survey sought to gather data from a wide range of trusts, i.e. offering the breadth of evidence for the study. It also comprised predominantly closed questions, which reduced the time investment required by participants, although the 33% response rate limits generalisability of findings. The case study and good practice examples were intended to understand, in-depth, the issues relevant to the particular local context but are necessarily few in number.

## Staffing arrangements

- The acute trust survey found that 15% of trusts (we use this term to refer to acute trusts throughout the report) would first contact social workers based at the trust if they had concerns about possible child maltreatment. Nine per cent of trusts said where the social workers first contacted were based would vary, and 71% that they would first approach social workers not based at the trust. This is likely to under-estimate the extent of hospital-based social work teams since some hospital-based social workers do not take referrals, but compared with other research it may suggest a fall in the prevalence of hospital-based social work teams.
- The case studies identified hospital liaison teams as well as full hospital-based teams – smaller teams where posts are not always based full-time at the hospital and that do not take referrals, but leading on liaison between trust and local authority. The other model of staffing identified in the case studies was community-based teams dealing with referrals, which provided a single point of entry to the social care service for all referrals from all agencies across the local authority. There were also references to arrangements in other (non-case study) local authorities where referrals are taken by locality-based teams (serving defined geographic areas within in the local authority) so that there are multiple points of entry.
- Hospital-based social work teams were reported to offer some very clear advantages and were very strongly endorsed by social work and hospital participants in case study interviews. They saw this model as supporting: more focus on safeguarding; faster response; better and faster communication and information-sharing; more joint working and joint training; better understanding of each agency; and stronger interagency relationships. In these areas it was seen as fundamental to effective and safe practice. But there were potential disadvantages noted too, specifically: a potential risk that the trust might rely too heavily on the social work team and take sufficient responsibility for child protection decisions and activity itself; and a concern about consistency with cases identified through other routes and in access to multi-disciplinary and community support.
- There were close working relationships and high levels of interaction between social work and hospital staff in all the case study sites with an in-hospital team. Among the community-based social work sites there was more variation, although some described levels of interaction and quality of joint work at least equal to areas with in-hospital teams.

- Local authority participants were extremely positive about the roles played by Named Nurses, Midwives and Doctors. Specialist midwives for vulnerable women also played an important part in safeguarding, along with other leads in key clinical areas, Paediatric Liaison Health Visitors or Nurses, and having 24/7 access to consultant paediatricians or registrars.

## Identifying cases where child maltreatment needs to be considered

- This study predates the announcement that the 'Child Protection – Information System' will be rolled out in NHS hospitals from January 2015 (Department of Health, 2012). Respondents, therefore, were asked about how they currently identify cases of suspected maltreatment and what works well, and less well, in doing so. Trust and local authority participants in the case studies were generally confident that opportunities to identify children experiencing maltreatment were not routinely being missed. However they recognised challenges in dealing with less obvious signs of abuse and with neglect, being too trusting of parents or too optimistic about their ability to change, balancing a focus on mother and unborn baby, and recognising safeguarding issues in adolescents. Trust and local authority participants also felt there was a risk of cases being missed by new or less experienced staff or those less skilled in talking with children and families.
- Clinical assessment was seen as the core of identification, and training and awareness-raising about child maltreatment as crucial. Various structured approaches to information collection and assessment were also used and thought to be helpful, provided they were clearly intended and used to support, not replace, clinical assessment.
- The case study sites recognised that adult ED attendance is an important way of identifying possible child maltreatment, and some reported increased identification of cases from adult ED. They had systems for routine inquiry to identify whether adult patients had dependents or for asking this where issues such as domestic violence, substance misuse and mental health problems had been identified.
- Gathering information was an important part of establishing levels of concern, and sharing information was an important activity in these cases. Trust staff from case study sites described this as involving clinicians, safeguarding team members, social care and community health services in particular, and there were also mentions of police, education and other community services. There was variation in how extensively information was described as being gathered or shared, how far it appeared to be a core part of the participant's work, the emphasis placed on gathering or sharing information, how far it was discussed

in the context of the decision to refer or as part of continuing work post-referral, and how far it involved helping patients to get support from other agencies.

- Just over half of trusts in the survey received a regularly updated list from the local authority of the names of children with a Child Protection Plan (CPP); 43% did not. Three-quarters (78%<sup>1</sup>) have a system for flagging that there is a CPP in hospital records, mostly an electronic system, and not always operating across all clinical areas. Sharing this information was seen by trust and local authority participants as important but there were real concerns that the focus should be on the child's presentation and that knowledge of the CPP should only lead to stepping up, and not stepping down, the level of concern. There were very scant references to having investigated the impact of this information on decision-making and actions locally.
- All trusts surveyed were able to contact children's social care to find out if the child was known to them. The information obtained was seen as important, with the same proviso that it should increase but not decrease concern levels.
- In the trust survey, 64% of trust participants agreed strongly that they were confident that staff know which cases to refer to social care. They reported high levels of access to clinical expertise from other hospital staff including out of hours, but lower levels of confidence that staff make full use of this expertise. Trust safeguarding staff often played an important role in the decision to refer to social care.
- Only 25% of trust participants in the survey agreed strongly that hospital staff have sufficient access to social work expertise when considering making a referral, and only 43% agreed strongly that it is helpful for staff to discuss potential referrals informally with social work staff. In the case studies, however, having access to advice from social care emerged as an important aspect of joint work.

## The referral process, response and subsequent work

- Eighty per cent of trust survey participants agreed strongly that staff know how to refer to social care. However, only 14% agreed strongly that ED staff always refer with sufficient information. The problems here identified by the case studies were insufficient information about the nature of or reasons for concerns, insufficient explanation of medical jargon or information, and clinicians being unwilling to put in the written referral what they had said verbally. Considerable amounts of time were spent by trust safeguarding staff

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<sup>1</sup> This is a higher proportion than those receiving a list because trusts also identify CPPs through direct inquiry to the local authority.

and local authority staff getting more information in these cases.

- Case study interviews illustrated that there were problems where hospital staff were thought not to understand the level of concern needed for a referral to be viable, or where views about what the threshold should be were not aligned between the local authority and trust. Developing a shared understanding had been the subject of much activity in the case study areas and was thought to be supported by training, informal discussion before referring, feedback on referrals, and closer working and liaison.
- Social care's provision of feedback on referrals was also seen as an area for more attention. In the survey, only 5% of participants agreed strongly that children's social care always give feedback on referrals, although some of the case study local authorities reported that feedback was given in the majority of cases. This information was seen as necessary for joint work and for clinical management, and important for educative reasons.
- Some of the case study sites had systems for picking up referrals that had been missed: either a review of all cases notified to the safeguarding team as a cause for concern, or a daily review – eg by the Paediatric Liaison Health Visitor – of the records of all child attendances in the ED.
- All trusts involved as case studies had a system for recording where a referral had been made, and in some of the sites, referrals were all copied to the safeguarding team. Not all trusts kept a central log of referrals made, and it appeared that this information was sometimes only available within case records.
- The case study trusts said that children were always admitted if this was necessary for further investigation or for their safety, even if there was no medical need, and several described themselves as having a lower threshold for admitting than other trusts. The trust survey found that 61% of participants said hospital staff always involve social care in discharge decisions where there are concerns about possible child maltreatment. This was seen as a crucial area of joint work in the case study sites. They had arrangements that required discharge to be signed off by a consultant (and in one case by the safeguarding team), described very active liaison with social care at this stage, and both trusts and local authorities in the case studies said that problems were extremely rare

## Building and supporting joint enterprise

- The case study sites described a range of operational and strategic meetings at which local authority and trust staff came together: psychosocial meetings (for information sharing and assessing the level of concern in individual cases); meetings to review cases and the issues they raised with a wider practice development focus; collaborative learning meetings involving larger groups of trust and local authority staff; safeguarding strategy meetings, and local multi-agency strategy meetings of which Local Safeguarding Children Boards (LSCBs) were key.
- The extent to which they happened varied in the case study sites. Some sites had each of the five types of meeting; others had no obvious place for strategic discussion below the LSCB level or no standing meetings to review individual cases or aspects of operational practice.
- Case study interviews identified that building relationships was also supported by: strong strategic leadership and vision; an organisational culture of learning and openness to challenge; easy communication pathways and strong working relationships between lead staff; mutual professional respect; familiarity and personal relationships; the quality and commitment of individual people; investment of time and effort; joint training, and multi-agency audits, inspections and peer reviews.
- Some interviewees highlighted concerns about where safeguarding fits within Clinical Commissioning Groups (CCGs), which will take over responsibility for commissioning most NHS services from April 2013. Although a focus on professional judgement rather than bureaucracy was welcomed, there were concerns that the shift away from central prescription and radical reduction of *Working Together* will lead to inconsistent local arrangements of mixed quality and effectiveness.

Looking across the areas of work discussed in the study, the table below summarises the key features of what would be the most comprehensive approach to joint work in cases where child maltreatment needs to be considered. It is a more comprehensive set of activities than those described by any individual case study area in the study, but it is a composite of the activities described, or aspired to, across all the case studies. We present this not as a recommended set of activity, but as a framework against which trusts and local authorities might together assess and strength-test their approaches and provision.

## Partnership working in child protection

<b>ACUTE TRUST</b>	<b>LOCAL AUTHORITY</b>
<b>Communication and availability</b>	
Core group of individuals, whether based in the trust or locality, who lead on liaison between the trust and the local authority and who develop strong relationships and open communication channels	
Invite and respond to social work input in cases causing concern	Social work staff available to attend hospital for immediate or planned joint work
Meetings and networks for regular liaison covering review of individual cases, operational issues, collaborative learning, safeguarding strategy, multi-agency strategy	
Joint training, supervision, peer review, audit	
<b>Identification of cases where child maltreatment should be considered</b>	
Training and working environment which supports clinical assessment based on holistic understanding of child safeguarding	Work with trusts to communicate information about thresholds and criteria for children's social care services
Possibly supported by structured checklists but their use and impact evaluated	Collaborate in development and evaluation of checklists
Information about children with a CPP or known to social care available across all clinical areas but used only to step up, not down, concern levels	Provide regularly updated information about child with a CPP to trust
Recognition of importance of adult ED in identifying child maltreatment and routine inquiry whether adults have dependents	Share information about adults known to children's social care appropriately
24/7 access to senior paediatric clinical expertise in cases causing concern	Staff available for informal discussion and advice pre-referral
Access to and notification of safeguarding specialist staff in cases causing concern	Staff available for informal discussion and advice pre-referral
Resources and agreed procedures for information sharing and gathering in cases where child maltreatment is considered	
Availability of and awareness among professionals of early intervention services and help available where referral to social care not appropriate, and appropriate referrals or signposting of services made	
<b>Referrals to social care</b>	
Threshold for referral is understood and agreed between local authority and trust	
Proactive approach to discussion pre-referral with safeguarding specialists and social care	Staff available for informal discussion and advice pre-referral
System for telephone referral or alert to referral, or other system for confirming referral is received	Immediate acknowledgement of referral however made
Follow up if feedback not received	Feedback on initial decision, staff contact details
System for checking cases not missed, eg review of cause for concern notification, daily check on all children's ED records	Feedback on subsequent activity and decisions
Regular audits of rate of referrals resulting in no further action, agreement on how to address	

Regular check or audit of sufficiency of information, agreement on how to address	
Escalation process in place if response to referral is not considered appropriate	
Referral or information-sharing discussed with family, consent obtained except where this would place child at risk	
Referrals copied to safeguarding team, logged and monitored	
Referrals clearly flagged in patient records	
<b>Pre-birth planning</b>	
Agreement about point at which pre-birth referrals will be accepted and pre-birth plans agreed which ensures timely preparation and allows for early births	
<b>Admissions and discharge</b>	
Clear understanding across clinical staff of when child is to be admitted including for safety	Staff available to provide information and advice to support decision to admit if needed
Clear procedure for involvement of social care and senior clinical and/or safeguarding staff in discharge decision	

# Introduction

## Introduction

This study was carried out by the Social Care Institute for Excellence (SCIE) as part of the programme of work of the Department of Health-funded Policy Research Unit in the Health of Children, Young People and Families (CPRU). CPRU is a collaboration led by the UCL Institute of Child Health in partnership with the National Children's Bureau, the Anna Freud Centre and SCIE.

The aim of the study was to understand how acute paediatric settings and local authority statutory child protection services work together in cases of suspected child maltreatment, and in particular:

- to describe arrangements at the interface between acute paediatric settings and local authority statutory child protection services
- to identify what is viewed locally as good practice in areas such as staff deployment, identifying cases where child maltreatment should be considered, referring cases to social care, information-sharing and discharge planning
- to explore what supports effective interface arrangements and local practice.

The study focused on emergency departments (EDs) and maternity services and their links with local authority social care. The project methods are described in Section 1.3 below and involved a survey of acute trusts and a survey of local authorities; qualitative case study research within 12 local areas, and a call for examples of effective local practice.

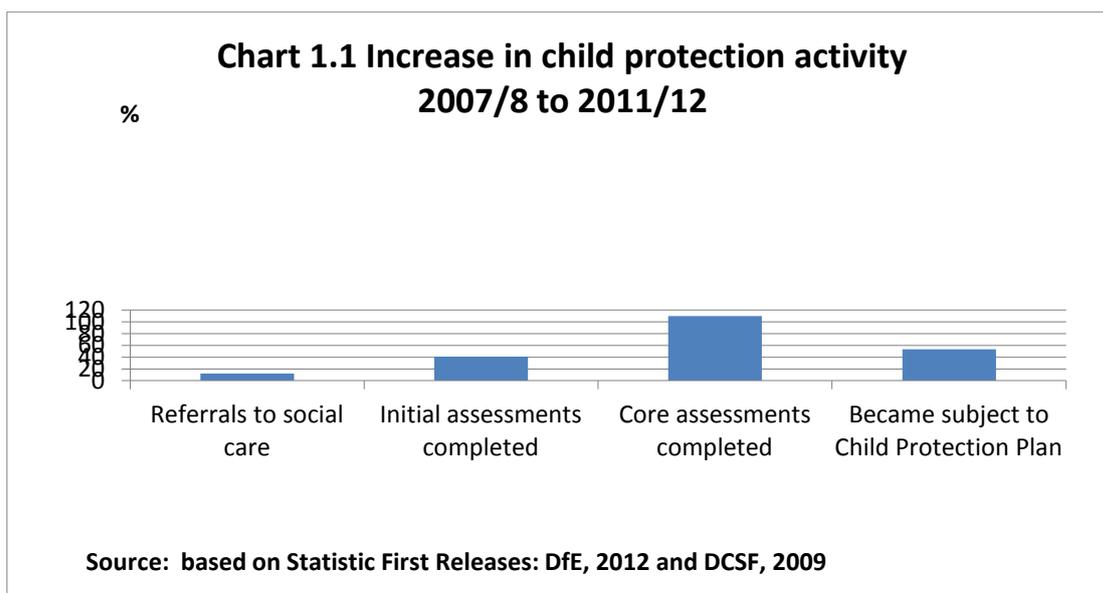
## Background

### **The burden and costs of child maltreatment**

The most recent population-based estimate of the prevalence of child maltreatment in the UK, carried out by NSPCC, (Radford et al, 2011) found that 14.5% of young adults aged 18-24 and 13.4% of 11-17 year olds were severely maltreated by a parent or guardian at some point in their lives. The study found that 2.5% of children aged under 11 (based on parent/carer report) and 6% of young people aged 11-17 (based on self-report) had experienced some form of maltreatment from a caregiver within the previous year. Child maltreatment has severe and long-lasting impacts on children affecting all aspects of their life and contributing to intergenerational harm (Brown and Ward, 2012; Davies and Ward, 2012; Gilbert et al, 2009a).

In the year to 31 March 2012 there were 605,100 referrals to children's social care; 168,270 children were identified as being in need because of abuse or neglect, and 52,100 became subject to a Child Protection Plan (DfE, 2012). There has been a rising trend in referrals to social care and in social work activity since Autumn 2008, when media reporting of the death of Peter Connelly and the publication of the first Serious Case Review sharply highlighted failures in interagency working as well as shortcomings within individual agencies. The fact that, as Table 1.1 shows, the use of

subsequent stages in child protection<sup>2</sup> has risen faster than the number of referrals also highlights a change in response in social work practice. The number of referrals fell slightly in 2011/12 compared with the previous year, whilst the use of subsequent stages continued to rise. The number of referrals now equates to an average of 3,980 per local authority over the course of 2011/12.



Research carried out by the Association of Directors of Children's Services (Brooks et al, 2012) in a series of surveys of local authorities exploring safeguarding pressures shows that the number of initial contacts has risen faster than referrals. Initial contacts are up by 51.5% on 2007/8 levels and equate to 1,853 per 10,000 0-17 population, an average of 18,462 per local authority in 2011/12. The ADCS research also highlights the considerable pressure this activity places on resources. An earlier report (Brooks and Brocklehurst, 2010), which matched data on local authority with data on the unit costs of safeguarding work, (Holmes et al, 2010) estimated that the total cost of dealing with initial contacts, referrals and initial assessments alone was £243.3m in England in 2008/9.

<sup>2</sup> A **referral** is a request for services to be provided by children's social care for a child who is not already assessed as being in need. A referral may result in an initial assessment of the child's needs, provision of information and advice, referral to another agency, or no further action. An **initial assessment** is a brief assessment of the child's needs which may lead to no further action, provision of services, or a more in-depth core assessment. If an initial assessment shows there is reasonable cause to suspect the child is suffering or likely to suffer significant harm, a section 47 enquiry including a more detailed **core assessment** is carried out. If concerns are substantiated by the core assessment and the child judged to be at continuing risk of harm, an initial child protection conference is carried out. The figure here includes both conferences resulting from section 47 enquiries and conferences for children on existing plans who transferred local authorities. At the initial child protection conference, a decision is made as to whether the child needs to become the subject of a **Child Protection Plan**.

These figures highlight the very substantial burden and costs created by child maltreatment for social care. The burden on health is also likely to be significant, despite evidence of under-recognition and under-reporting of child maltreatment (see below). Current NHS procedures for payment of hospitals do not take account of costs associated with referral to social care. There is no standardised way of recording this activity within diagnostic coding or procedure codes, which means the costs involved cannot be accurately assessed or monitored. There is very little information about the volume of work relating to child maltreatment undertaken by health professionals. The social work department of one London teaching hospital, which records referrals made by hospital staff to all local authorities, recorded 365 referrals over the course of the year 2011-12 (Patterson, personal communication, October 2012).

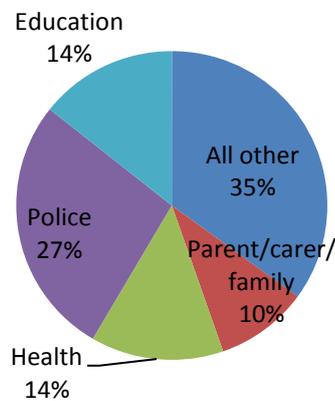
### **Under-recognition and under-reporting of child maltreatment**

However, there is a substantial gap between the rates of maltreatment reported by victims or parents and the rates of maltreatment substantiated by child protection agencies. The rates of 2.5-6% for maltreatment within the last year are much higher than the rate of children identified as being in need because of abuse or neglect (1.48%) or becoming subject to a Child Protection Plan (0.46%), based on the Children in Need census (DfE, 2012). It also suggests that most maltreated children are not known to social care and are not receiving services (MacMillan et al, 2003; Woodman et al, 2008). As Gilbert et al (2009b) say, the discrepancy between population-based reporting of prevalence and social work agency statistics of activity is likely to indicate failures to recognise child maltreatment and failures to report as well as failures of agencies to respond and substantiate maltreatment.

There is a growing body of evidence in the UK and elsewhere that professionals in health and other service areas vary in their ability to identify child maltreatment and under-report the cases where they do suspect child maltreatment (Davies and Ward, 2012; Gilbert et al, 2009b; Lazenbatt and Freeman, 2006; Woodman et al, 2008; Tompsett et al, 2009). Emotional abuse and neglect, and neglect in older children, raise particular challenges and may be particularly under-recognised (Daniel et al, 2009; Rees et al, 2011; Stein et al, 2011). Analysis of the coding of hospital admissions for injury (Gonzales-Izquierdo et al, 2010) shows that 6.4% of the admissions of infants and 1.5-2.1% of those of older children under five were coded as being for maltreatment-related reasons – a level the authors note as unexpectedly low. Research among general practitioners also showed low levels of coding of maltreatment and considerable uncoded activity (Woodman et al, 2012).

Only 13.8% of referrals to social care are made by health agencies (Brooks et al, 2012), and research for the ADCS shows that the proportion made by health has fallen slightly between 2011/12 and 2007/8, whilst the proportion made by education and police has risen.

**Chart 1.2 Referrals by source 2011/12  
(Brooks et al, 2012)**



The barriers to reporting, and to wider interagency collaboration between health and social care, have been extensively documented (see for example Brandon et al, 2010; Daniels et al, 2009; Datta and Hart, 2008; Davies and Ward, 2012; Gilbert et al, 2009b; GMC, 2011; Howarth, 2009; NICE, 2009; Tompsett et al, 2009). The key barriers that emerge are:

- failure to recognise abuse and neglect; different professional approaches to and perceptions of child maltreatment; different perceptions of the likelihood of significant harm; different thresholds (formal or personal) for intervening and different interpretations of thresholds; reluctance to act if the signs are not clear-cut
- over-confidence in what parents say especially when there is no perceived intention to harm the child; fear of the loss of a positive relationship with the family; divided duties to adults and children; uncertainty about when to mention suspicion, what to say to parents and carers and what to write in the clinical file
- uncertainty or confusion about information sharing and confidentiality; limited reach of training; difficulty keeping up to date with guidance; concerns about challenges from parents and fear of accusations of malpractice and litigation
- poor communication: inadequate information sharing, delays and inaccuracies, exacerbated by practical difficulties arising from different working arrangements which make it difficult for professionals to meet or talk, reorganisation and staff turnover, and pressure on time
- the high level of anxiety that safeguarding and child protection raises across professions

- lack of confidence that making a referral will lead to effective support for the child or family; poor experiences of making referrals to social care; doubts about the quality and efficacy of social work referral processes and practice; scepticism about whether a referral will result in suitable action and about the availability of resources; lack of feedback about actions and decisions following referrals; concerns about escalation and loss of control and the time-consuming nature of child protection processes
- lack of clarity about the roles of different professions; imbalance in status and power between professions; misunderstandings and mistrust.

Davies and Ward (2012), reporting on a programme of studies on child maltreatment, with a particular focus on emotional abuse and neglect, which included studies looking at identification and response in health professions, note that there is a focus on referring or reporting rather than on direct action:

*Response tends to be conceptualised as ‘referral’ or ‘reporting’ and this is where the bulk of evidence lies. Professionals outside social care are reluctant to take direct action other than to refer to social care agencies. They appear to be frozen by the decision to refer or not to refer rather than to consider what other forms of action might be useful and appropriate.*

Davies and Ward, 2012: 50

There is a growing use of screening instruments and protocols in health services to assist in the identification of cases where child maltreatment should be considered. A number of systematic reviews have highlighted the paucity of robust evidence of their value and impact. There are concerns that their predictive value is low and that the risk of false positives (inaccurate identification of cases as involving maltreatment) means their use would overwhelm child protection resources (Barlow et al, 2012; Carter et al, 2006; Peters and Barlow, 2005; Woodman et al 2008 and 2009).

The role of professionals in adult health services in identifying potential child maltreatment is also increasingly recognised, although Davies and Ward (2012) highlight that opportunities for identification are still missed. A study in a London hospital (Carroll et al, 2012) found that parental behaviour or need were the main reason for discussion of 39% of the 64 children discussed at psychosocial meetings for children admitted to paediatric wards. Only a minority of concerns were prompted by child injuries. An audit of another London hospital found that 25% of the eCAFs<sup>3</sup> completed by the Accident and Emergency department over a six-month period were for adult presentation (Gilbert, personal communication, October 2012).

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<sup>3</sup> The national eCAF system, which has since been decommissioned by the DfE, was the electronic enablement of the Common Assessment Framework, used to assess children’s additional needs and decide how they should be met.

The high prevalence of child maltreatment, coupled with the difficulties inherent in accurate identification and risk assessment and the danger of overwhelming social care resources with referrals, support the view that public health responses with a focus on early intervention and parenting support are essential to ensure that all children are protected adequately (see for example Barlow and Calam, 2011; Barlow with Scott, 2010).

### **Interagency working on child maltreatment: recent policy and professional guidelines**

The Munro Review of Child Protection (Munro, 2011; Munro, 2012) and the Government response (DfE, 2011) has had a major influence on the direction of child protection policy and practice. The review emphasises the need for more space for professional expertise and judgement. It recommends a radical reduction in the amount of central prescription of processes and timescales, initiatives to improve social work education and practice, and the need for a better understanding of risk and uncertainty within social work practice. It makes the case for a multi-agency approach to early intervention and prevention, recommending a duty on local authorities and statutory partners to secure sufficient early help services (not accepted in the Government response), and that children and families should receive early help where their needs do not meet the threshold for children's social care services. It highlights that the signs of abuse and neglect are often ambiguous and emphasises the importance of those working with children and young people having ready access to social work expertise to discuss concerns and decide whether a referral is needed.

The review calls for a role for Local Safeguarding Children Boards to monitor the effectiveness of early intervention and to ensure multi-agency training remains available. It highlights the importance that changes in the structure of health services do not jeopardise the role of named and designated professionals for safeguarding or erode the focus on safeguarding within the NHS. The Government response confirms that the improvement of arrangements for protecting children in health services should continue, and that Clinical Commissioning Groups and the NHS Commissioning Board will be required to make arrangements for safeguarding and promoting children's welfare.

Interagency responsibilities for child protection are currently set out in *Working Together* (DCSF, 2010) although this is in the process of being revised (following recommendations in the Munro Review) and there has recently been consultation on a radically shortened document. The 2010 version emphasises that protecting children from harm requires effective joint working between agencies and sets out the actions required from each. *Working Together* emphasises that health professionals and organisations should ensure safeguarding and promoting the welfare of children is an integral part of their work. Health professionals should be able to recognise risk factors, provide preventative support, know where to refer for help and participate in child protection work. All staff working with children should have safeguarding training at varying levels. The links between adult problems and children's needs is highlighted. NHS trusts should have a board executive lead for safeguarding and a named doctor,

nurse and midwife (if they provide maternity services) for child protection. Specialist paediatric advice should be available at all times to Accident and Emergency departments and other units where children receive care. Concerns about a possible child in need should be discussed with a manager or named or designated professional.

The importance of strong interagency working and information-sharing, and of each profession being trained in safeguarding practice and alert to the indicators of child maltreatment has been emphasised in many professional guidelines and standards, particularly the National Institute for Health and Clinical Excellence (NICE) guidelines *When to suspect child maltreatment* (NICE, 2009), the Intercollegiate Document on safeguarding (RCPCH, 2010) and the Intercollegiate Committee standards for children and young people's emergency care settings (RCPCH, 2012). The General Medical Council's *Protecting Children and Young people: the responsibilities of all doctors* (GMC, 2012), sets out that all doctors must consider the needs and wellbeing of children and young people, be aware of risk factors linked to abuse and neglect, consider whether adult patients pose a risk to children or young people, and seek advice from a named or designated professional, lead clinician or other experienced colleague. They must understand the roles of other professionals and agencies and participate in child protection procedures locally.

The NCB study of working arrangements between hospitals and children's social care (Datta and Hart, 2008) strongly endorsed the hospital-based social work model. Based on surveys of hospitals and local authorities, it found a hospital-based service was provided in 47% of hospitals. Part of the background to this study was recognition that some local authorities have withdrawn hospital-based teams and that it is timely to explore how strong interagency working can be supported in a range of models.

## Research methods

As we noted, the study focused on how EDs and maternity services work with local authority child protection services. It involved four research components:

- a Call for Practice issued by SCIE in early 2012 asking for examples of effective local practice, submitted on a structured template with seven substantive fields about the initiative. Eight examples were submitted of which five are summarised in this report, identifying the organisation submitting the example. Details of sites excluded can be found in the Appendix.
- an online survey of local authorities carried out in early 2012 covering their liaison with both EDs and maternity services in the acute trust with which they mainly work. The response rate was too low to allow quantitative analysis – 18 of 152 local authorities (a response rate of 12%) began the questionnaire but the number responding to individual questions was often below this. Because of this we do not use the data in this report, but the survey was used to inform the case study stage and site selection.
- an online survey of acute trusts. This asked questions relating to the main local authority with which they work. It was issued to trust executives, suggesting Named Nurses as the most appropriate participant. The survey focused only on

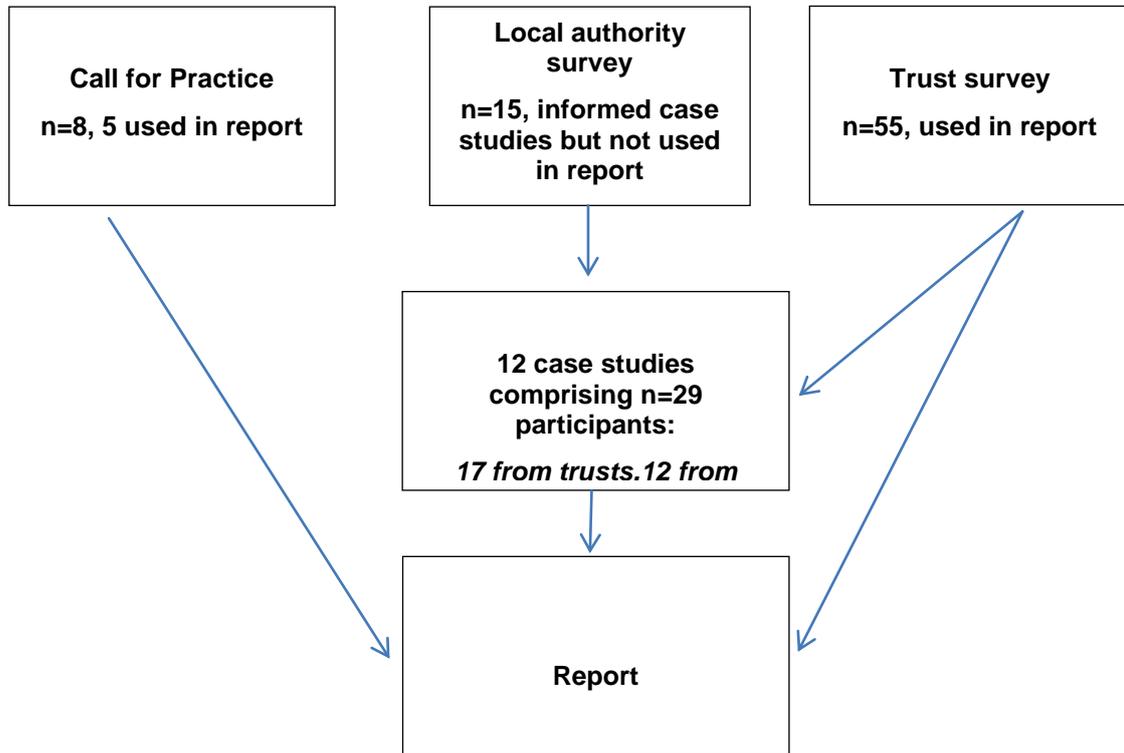
ED liaison with social care to ensure it could be completed by a single participant, and 55 of the 164 trusts approached responded (a response rate of 33%).

- a case study stage involving twelve sites. The case study sites were purposively selected to include only sites where there was evidence – mostly from information in the surveys but also based on advice from the Advisory Group and other information – of more extensive or effective joint work (see Appendix for discussion of the measures used). The reasoning here was that the existing literature, and our acute trust survey, have identified problematic aspects of practice, and that we can learn most by seeing how these and other issues have been addressed in areas with more effective joint work. It is important to note that we were not able to use information about the number of referrals or rate of admissions for child maltreatment as part of our selection criteria as it is not collected systematically and consistently.

We also aimed for a balance of geographic area, type of local authority and whether or not there was an in-hospital social work service. The intention was that each case study should involve the local authority and the acute trust, with the suggested participant for the local authority being a head of service or team manager and for the acute trust a Named Nurse and/or Midwife. If the organisation had taken part in a survey, the survey participant was also the informant in the case studies. Twelve acute trusts (with 17 trust informants overall) and ten local authorities (with 12 participants overall) took part. Interviews were conducted by telephone except two, which were carried out face-to-face. All interviews were digitally recorded. They were analysed using the Framework analysis method (Ritchie et al, 2003; Spencer et al, forthcoming 2014 – see the Appendix for further details). Verbatim quotations are used in this report, shown in italics, without identifying the organisation involved.

The study design is summarised in Figure 1.1 below.

**Figure 1.1 Summary of study design**



## The study participants and the study data

This section provides more information about the organisations and individuals taking part in the study, and about how the data have been used in the report.

The local authority survey, as noted above, was used to identify case study sites and to shape issues for discussion in the case study stage. One of the final questions in the survey asked participants whether they would be willing to be approached to take part in the case study stage, and if so to give their contact details. These details, provided by ten participants, allow us to identify the region, local authority type and job title of the person completing the survey. These data show that surveys were completed by local authorities from all regions except the South West and the East Midlands, and from London Boroughs, Shire Counties and Metropolitan Districts but not from any Unitaries. Those completing the survey were predominantly Service Managers or Heads of Service, with some participants identifying themselves as Team Manager or Assistant Director.

Similarly, in the survey with trusts we have information about 38 of the trust sample who provided contact details for re-contact. The geographic spread is shown in Table 1.1 below, using the Strategic Health Authority areas. We had coverage in the survey of eight of the ten SHA regions (no participants from East Midlands or North East). Nine of the 38 trusts taking part were based in London.

<b>Region</b>	<b>Number of participants</b>
South West	6
South Central	6
South East Coast	2
London	9
East of England	3
East Midlands	0
West Midlands	4
Yorkshire & The Humber	4
North West	4
North East	0
<b>Total</b>	<b>38</b>

In terms of who completed the questionnaire for the trust, as the table below shows, in 27 of the 38 cases where this information was known the questionnaire was completed by a Named Nurse for Safeguarding or Child Protection or a nurse lead for safeguarding under a different title.

<b>Table 1.2 Trust survey sample: job title</b>	
<b>Job title</b>	<b>Number of participants</b>
Named Nurse <sup>4</sup>	27
Named Midwife	2
Designated or Named Doctor	2
Named Nurse and Named Doctor <sup>5</sup>	1
Director of Safeguarding, Head of Safeguarding or Safeguarding Practitioner	3
Medical Director	1
Nurse Consultant or Head of Nursing	2
<b>Total</b>	<b>38</b>

As we noted above, the case study sites were purposively selected using information from the local authority and trust surveys, advice from the Advisory Group and other field intelligence, to identify those where there were indications of more extensive or effective joint work. The Appendix provides further information about the measures used. The intention was that each case study should be a 'pair' consisting of a trust and a local authority. Where the selected trust or local authority had taken part in the survey, we approached the survey informant about participating in the case study. We had asked those taking part in the surveys to indicate the trusts or local authority with which they work most closely, and we used this information to identify the appropriate trust or local authority to create case study 'pairs'.

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<sup>4</sup> Includes Named Nurse for Child Protection, Named Nurse for Safeguarding, Lead Nurse for Safeguarding, Consultant Nurse for Child Protection, Named Nurse & Nurse Consultant, Named Nurse and Named Midwife (unclear whether a single role or two individuals completing the survey together), Named Nurse & Matron

<sup>5</sup> Questionnaire completed by two individuals together

We approached 12 case study 'pairs'. All 12 of the trusts and 10 of the local authorities agreed to take part. As well as an orientation to those where there was an indication of more extensive or effective joint practice, the sample was also purposively selected to ensure a spread of:

- social work service model: to include in-hospital and community-based teams, based on information provided in the surveys
- type of local authority: to include shire counties, unitaries, metropolitan boroughs and London boroughs. Although these categories pertain to the local authority and not to the trust, they give some indication of the local area served by both organisations
- region: eight of the nine local authority regions and nine of the ten Strategic Health Authority areas were represented in the sample; four of the twelve sites were in London.

Where the organisation had taken part in either the local authority or trust survey, the survey participant was interviewed as the case study participant. Where they had not taken part in a survey, we suggested the appropriate participant for the local authority would be the relevant head of service or team manager, and for the acute trust would be the Named Nurse and/or the Named Midwife. We discussed with those approached whether we should involve a second participant from their organisation; this decision was sometimes made at this point and sometimes only after they themselves had been interviewed. Interviews were conducted with 12 local authority participants (two local authorities putting forward two participants to be interviewed) and with 17 trust participants (five trusts putting forward two participants to be interviewed).

Table 1.3 shows the case study sample.

<b>CASE STUDY</b>	<b>REGION</b>	<b>SOCIAL WORK SERVICE MODEL</b>	<b>LA TYPE</b>	<b>LA PARTICIPANTS</b>	<b>TRUST PARTICIPANTS</b>
<b>AREA 1</b>	South West	Hospital team	Unitary	Team Manager of hospital team	Named Nurse
<b>AREA 2</b>	South East / South Central	Hospital team	Unitary	Did not participate	Named Nurse
					Head of Midwifery & Women's Services
<b>AREA 3</b>	London	Hospital team	London Borough	Team Manager of hospital team	Named Nurse
				Service Manager – assessment and early intervention	
<b>AREA 4</b>	London	Hospital team	London Borough	Team Manager of hospital team	Named Nurse

					Named Midwife
<b>AREA 5</b>	London	Hospital liaison team	London Borough	Operations Manager for Safeguarding	Named Nurse
<b>AREA 6</b>	London	Hospital liaison team	London Borough	Head of Referral & Assessment Service	Named Nurse
				Deputy Head, Referral & Assessment Service	
<b>AREA 7</b>	North East	Community-based	Metropolitan	Did not participate	Named Midwife
<b>AREA 8</b>	North West	Community-based	Unitary	Strategic Lead for Safeguarding	Named Nurse
					Named Midwife
<b>AREA 9</b>	West Midlands	Community-based	Metropolitan	Head of Safeguarding	Named Doctor
					Joint Named Nurse & Named Midwife
<b>AREA 10</b>	East of England	Community-based	Shire	Safeguarding Strategy & Commissioning Manager	Joint Named Nurse & Named Midwife
					Named Doctor
<b>AREA 11</b>	South East / South East Coast	Community-based	Shire	Team Manager, Referral & Assessment	Named Nurse
<b>AREA 12</b>	Yorkshire & The Humber	Community-based	Unitary	Service Manager, Safeguarding & Children in Need	Head of Safeguarding

As the table shows, the local authority sample included all four types of local authority, although with an orientation to London Boroughs and unitaries. Six of the 12 trusts involved in case studies have Foundation Trust status. All but three have multiple hospital sites, and three are an integrated trust for acute and community services. Around half are teaching hospitals and several are specialist centres, including for paediatrics, with some having separate children's hospitals. All take children from more than one local authority, in particular those that are specialist centres, and in some cases we were told that the local authority they work with most accounts for under half of their child patients. This meant they were able to compare approaches to joint working across local authorities. They varied in size from a little over 2,000 staff to well over 8,000<sup>6</sup>, including among the largest in England. The smaller trusts covered either small urban areas or large but less populated geographic areas; the larger trusts

<sup>6</sup> Based on information from trust websites as this information was not always known to the case study participant

covering either large geographic areas or were city-based and provided specialist services not only to a large urban area but also to other areas.

The report draws together the trust survey data (based on what was intended to be a broadly representative sample of England acute trusts) with the case study data (based on a purposive sample of local authorities and trusts which appeared to have more advanced joint working practices).

The survey data were analysed in Excel. The survey sample was too small to permit sub-group analysis.

The case studies were carried out using qualitative research methods, with in-depth interviews following a topic guide listing key themes and issues to explore rather than prescribed questioning. In almost all cases interviews were carried out by telephone, and always at a pre-arranged appointment time. One trust interview and one local authority interview were carried out face-to-face, and in the case of the local authority this was with two participants at their request. Interviews generally lasted for around an hour and were in all cases conducted in a single session.

Using qualitative research methods meant that questioning was responsive to the local context and arrangements described, and that the study participant's perspective and views were captured with their own emphasis and in their own words. All interviews were digitally recorded to capture this, and analysis was carried out from the verbatim recording. A thematic analysis was carried out, summarising interview data within each case study under the relevant topic headings (see the Appendix for more information). This analysis is used in the report to describe the range of arrangements, processes, views and so on. Since it is qualitative data it has not been analysed quantitatively, although where appropriate some indication of the weight of opinion is given.

The analysis looks across the samples of trusts and local authorities rather than describing 12 discrete case studies or 22 discrete organisations. The emphasis is on findings that are likely to be relevant and useful beyond the individual case studies and organisations involved. The report therefore does not provide the specific organisational context/s for each finding, although we provide some brief (and non-identifying) context in quotation attributions. We have drawn out distinctions between trusts on the one hand and local authorities on the other where these were apparent in the data, although it is worth noting that there was much shared ground in what trust and local authority participants had to say, and sometimes the differences between case study areas were more apparent than between trusts and local authorities.

Finally, the survey and case study data essentially capture study participants' views, perceptions and assessments. These are based on experience and on more formal processes such as Serious Case Reviews, monitoring and audit, but there were relatively few references to research or evaluation evidence underpinning the views expressed.

## The structure of the report

Section 2 looks at how local authorities provide a social work service to the trust and at trusts' staffing arrangements for safeguarding work, the pros and cons of different arrangements and what needs to be in place to support them. Section 3 looks at how trusts identify cases where child maltreatment needs to be considered and the decision to refer to social care. Section 4 looks at the referral process, the quality of referrals and subsequent joint work. Section 5 looks at building and supporting joint work and a sense of joint enterprise. The final section is a brief discussion of key emergent issues.

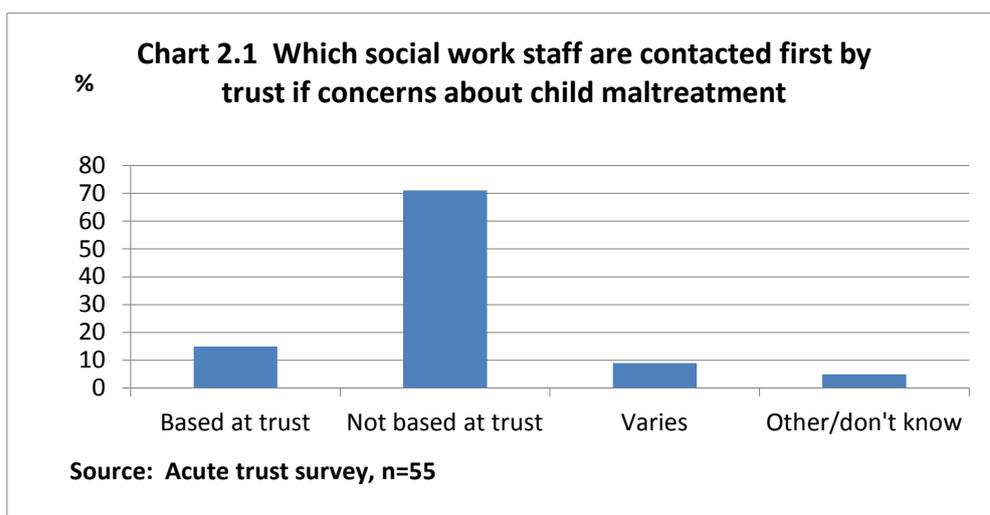
## Staffing arrangements

### Social work staffing arrangements

Previous research has highlighted the value placed on in-hospital social work teams (Datta and Hart, 2008). An objective of this research was therefore to explore the range of staffing arrangements, their respective advantages and disadvantages, and how different staffing arrangements need to be supported to contribute to effective joint working.

In the acute trust survey, 71% of trusts said their first contact with social care in cases arising in the ED that raise concerns about possible child maltreatment would be with social work staff who are not based at the trust. For 15% it would be with social work staff based at the trust, and in 9% of cases it would vary<sup>7</sup>. This suggests that at least 29% of trusts may have some hospital-based social work support, although our question focused specifically on first contact where there are concerns about child maltreatment and some hospital-based social work teams do not take referrals. The broad models that emerged in the case studies were:

- dedicated in-hospital social work teams
- smaller hospital liaison teams where staff were not based at the hospital full time
- community-based teams
- in addition, two case study areas had previously had a single liaison social worker but had since moved to a community-based social work service.



<sup>7</sup> The NCB research (Datta and Hart, 2008) found that 47% of local authorities reported having a hospital-based social work team. Our local authority survey found that five out of 18 local authorities (28%) had one. Our data may therefore indicate a fall in their prevalence, although the surveys are not directly comparable and our local authority sample was too small for reliable use.

### **In-hospital social work teams**

The case study sample included four hospital-based social work teams (plus two with hospital liaison teams based partially at the hospital – see below). They varied in size across the case study and local authority survey examples from four to nine full time equivalent social work posts, plus manager, social work assistant and administration posts. They were generally located with or very close to the hospital safeguarding team, and in some hospitals there were also co-located police posts. Out of hours, trust staff refer to a community-based emergency duty team.

All the hospital-based teams were involved in information sharing, informal discussion with trust staff and took referrals from the hospital. However, there were a number of variations within the broad hospital-based model:

- the emphasis placed on giving informal advice: all teams gave informal advice, to clinicians and to trust safeguarding leads, on how to deal with cases and whether or not to refer them. Trust safeguarding also gave informal advice to colleagues, and there was some variation between case study sites in the relative emphasis on social workers or trust staff as the main or first point for staff wanting informal advice
- whether or not social workers were linked with specific wards or medical specialities: for example one social work team manager described individual team members specialising in cystic fibrosis, HIV, renal problems, pregnant women with substance misuse and teenage pregnancy
- the extent of involvement in case work where the case had been referred by the hospital: for some, case work usually stopped at the initial assessment or strategy discussion; for others it extended into core assessments, legal proceedings or longer, either for most cases or particularly where more specialised health issues were involved and where there was likely to be more continuing liaison with hospital staff. One hospital-based social work team in the case studies was carrying cases for longer than intended due to capacity constraints in locality teams, and this was putting pressure on staff and on relationships with the trust
- whether or not the team also had a caseload of community-based cases (ie cases not referred by the trust): two case study hospital teams carried out pre-birth assessments across the local authority. In another trust, the team had previously carried out early intervention work with families linked with the hospital or had provided support for children in need, but the rising number of child protection referrals within the hospital meant they no longer did this work
- whether or not the team also took referrals on behalf of other local authorities: two teams still took all or some referrals for other local authorities, passing information on to the relevant other local authority. Others had ended this practice – either because of capacity constraints or because of concerns about

holding risk and making threshold decisions on behalf of another local authority. However, some teams continued to offer support to out of authority cases by providing contact details to clinical or safeguarding staff, following up where the trust was concerned about the response to a referral, and providing cover in meetings. Where there was less support, trust participants sometimes commented on the additional workload that now fell on trust staff and on the difficulty of building good relationships with multiple local authority teams

- whether the main local authority social work service was set up as a single referral and assessment unit or involved a multi-agency referral arrangement: see below for further information.

**Call for Practice example: Processing referrals and notifications to other local authority children's services. Submitted by: Wandsworth Children's Specialist Services based at St George's Hospital, South West London**

Referrals, particularly from midwifery, are channelled through the Wandsworth social work team based at the hospital regardless of the child's residence, along with notifications of attendance in ED by looked after children and children with Child Protection Plans. They are also recorded on the Wandsworth database. Trust staff can be confident that the referral has been sent and followed up to confirm receipt and the response is tracked. This is important given that some local authorities have high thresholds for accepting referrals of unborn children. Information gaps can be identified and filled before the referral is sent on. Wandsworth say this confidence has helped to increase the referral rate.

The survey and case study work showed that some local authorities had withdrawn in-hospital teams, replacing them with smaller peripatetic or liaison teams or with community-based provision. These changes were prompted not only by budget cuts but also by a desire to clarify pathways, provide more consistency in responses across the borough, rationalise management resources, and fit with new approaches to multi-agency and community-based working. The changes, which had sometimes been very contentious, particularly against a backdrop of high profile local child protection cases, were initiated by the local authority but had involved discussion and liaison with the trust to embed new arrangements. The local authority survey also included one area where the in-hospital team's work was being expanded to include taking referrals from the ED and another where a hospital-based team had recently been established.

### **Hospital liaison teams**

Two of the case study areas had a smaller number of social work posts designated to work with the trust but not always based there full time, carrying a mixed case load of hospital and community cases and not taking referrals. These were sometimes described as hospital liaison teams and this is the term we use in this report. In both these areas, referrals were made to a single multi-agency team involving all or some of social workers, police, health, education and housing, who jointly considered each referral, shared information and made decisions about next steps. These arrangements

are sometimes known as Multi-Agency Safeguarding Hubs (MASHs – see for example Golden et al, 2011). The designated social workers had offices at the hospital, attended meetings, carried out joint assessments and other work with trust staff, provided informal advice and were the key link between the local authority and hospital.

### **Central community-based teams**

The remaining six case study local authorities operated through a central community-based team, which took all referrals from all sources across the borough, providing a single point of entry by telephone, fax or email to the referral team. For four of the case study sites, this was a social work team, working under names such as Central Access Point, Referral and Assessment Service or Duty and Assessment Team. For two it was a multi-agency arrangement, in one case involving police co-located with the social work referral team and in another a MASH drawing together social care, police and health. In either system, cases that met the threshold for social work intervention were subsequently passed on to case-working teams, either a central team or one of a number of locality-based teams.

Two further variants to the community-based model were described by case study participants as operating in the past or in other local authorities, but not currently by the local authorities involved in the research:

- multiple points of entry – where referrals were not made to a single referral team but to separate locality-based teams covering designated geographic areas. None of the case study local authorities operated this system, but some case study participants referred to it as the system used in other local authorities
- a single liaison social worker based at the hospital, with referrals made to and case work carried out by community-based teams. In both cases the liaison social worker had been employed part-time and term-time only. Both local authorities had moved from this to a single community-based access point, and local authority and trust staff found this a more effective arrangement. Although a local presence for informal advice, access to social work information, discussion and attendance at meetings had been useful, it was not viewed as a sufficiently robust pathway and it had been problematic for the trust not to have a consistent procedure in place across the week and year.

In the rest of this report we use the broad categories of hospital-based (including both full on-site teams and hospital liaison teams unless otherwise stated) and community-based teams, although as we have described, the particular arrangements vary within these models.

## The advantages and disadvantages of different staffing arrangements

Case study areas with an in-hospital social work service endorsed the value of having a social work team on site very strongly. Both trust and local authority participants saw it as central to having established strong inter-agency relationships at operational and strategic levels, and fundamental to their safeguarding practice. There remained considerable regret, even several years later, in some – although not all - trusts where the in-hospital service had been withdrawn. In some of these cases, trusts reported still having stronger relationships with individuals or teams that had previously provided the hospital-based service. For instance, one trust participant said that information sharing is much easier with the locality team to which several of the hospital-based social workers had been moved, several years earlier, and that this team attended regular meetings on pre-birth assessments which other locality-based teams did not attend.

Positive working relationships were not confined to areas with an in-hospital service, and some case study areas had developed working relationships with a high level of liaison and shared work through other means. However there were also areas with community-based teams where relationships were described as less close and where much less joint work was reported than areas with hospital-based social workers.

The advantages of hospital-based teams were very clear to areas with these arrangements. Having staff on-site meant they were available and accessible. This was important for:

- raising the profile of child maltreatment and safeguarding within the trust. Although trust participants viewed this as an important part of their own roles, both hospital and social work staff felt that for social workers to be seen in the hospital and to be viewed as an integral part of the hospital system was an important message about the priority of safeguarding in the trust
- informal communication and interaction, including seeking advice on cases that caused concern where it was not clear if a referral should be made. Giving informal advice was also a key role of hospital safeguarding staff, as we discuss below, and community-based teams also provided informal advice. Some said that hospital staff used it very actively and constructively, whereas others said that it was rarely sought. However, the value of being on hand for informal advice was stressed heavily in areas with in-hospital social work teams. One team manager, for example, felt that being seen on site prompted conversations and referrals that would not otherwise have happened:

*'We have a great relationship with the midwives, you see them every day .... Consultants knock on the door and say "can I have a word, I just want to talk this through" .... Those conversations would not happen if we were in another building. Obviously people could pick up the phone but it's different .... [The outcome of conversations] is "you need to do something, you need to refer that or you need to talk to so and so" .... My gut feeling is that*

*[without the hospital social work team] there would be fewer referrals.' Local authority, hospital-based social work team.*

- speed of response and information sharing. Hospital-based social work teams were able to respond immediately and to share information and the process of gathering more. Some hospital safeguarding professionals felt that too much information gathering fell on them because the community-based social work team was not able to respond quickly enough. Being on site was also seen as important by local authority and trust staff for sharing information about next steps and the outcome of referrals
- seeing the child and family. Being able to carry out speedy and sometimes joint assessments and interviews was seen as important, and preferable for the child and family than a delay in being able to leave or a subsequent home visit. The complex and nuanced nature of cases involving suspected child maltreatment was emphasised. It was felt to be sometimes difficult to convey concerns – and particularly a third party's concerns – adequately over the telephone, so for the social worker to be able to see the child was important
- a better understanding among social workers of conditions and procedures which are more commonly seen in cases arising in hospitals than in the community. Examples given here were severe physical injury and procedures for assessing how it might have been caused, the implications of non-engagement with medical services or treatment, and fabricated or induced illness
- more active case management, particularly important in pre-birth cases and in the early days after birth – work that was seen as particularly anxiety-inducing because of the very young age and extreme vulnerability of the child
- a better shared understanding of social work child protection thresholds, the types of cases that should and should not be referred and the information required for a good referral
- attending meetings: both meetings on an individual case such as strategy meetings, discharge planning meetings and pre-birth planning meetings, and regular meetings to review cases causing concern or to develop and implement policy
- developing an understanding of each other's systems, procedures, pressures, operating environment, roles and expertise, and for social workers to develop a better understanding of medical expertise and terminology
- delivering joint training: mostly although not entirely confined to case study areas which had in-hospital teams

- and overall relationship building.

In these areas, the hospital-based team was seen as fundamental to effective and safe practices.

*'I think it makes a massive difference [having an on-site social work team] because they have a good understanding of the processes that take place within the acute hospital and they're on site so they're accessible .... Things are picked up very quickly .... So I think there's qualitative untold benefits as well as benefits you can clearly document and see .... Relationships – absolutely – and familiarity with processes, who to access, where to go for information .... The right person to talk about things with so you're effective immediately.'* Acute trust, hospital-based social work team.

However, elsewhere community-based teams were seen as having particular advantages, and hospital-based teams as having potential shortcomings:

- clear commitment on the part of the trust to decision-making and action in cases where child maltreatment was considered. There were concerns among both local authority and trust participants that having a hospital-based team might lead to over-reliance on social workers. Where cases that are well below the threshold are referred to the social work team, the social work team takes on information collection and decision-making, which in other models would be done by the trust. This was expressed as a hypothetical concern in some areas with community-based teams, but was also described as having been the situation in one area, which had moved away from having a full hospital-based service. Here both the local authority and the trust felt that the trust was more fully and appropriately involved in safeguarding activity and decisions under the new arrangements.

*'The medics didn't have to get involved with any kind of child protection or social care issue at all because they literally delegated it all to the hospital social workers.'* Local authority, community-based social work team.

Within the case study data, there was no indication that trust safeguarding teams were less active in trusts which had an in-hospital social work team, and neither the trust nor the local authority in these cases felt the trust was over-reliant on the hospital-based social work team.

- social workers having direct connections with social work professional practice, networks, leadership and identity through being based in the central borough team. This was acknowledged as a possible shortcoming by some in-hospital teams who mitigated it through management and supervision and stressed the

importance of hospital-based social workers engaging with central department practice and development

- consistency in decision-making and practice. There were concerns about hospital- and community-based teams making different decisions following referrals. These were addressed in part in one area with an in-hospital team by a fortnightly panel, which reviewed decisions about entry into care made for both hospital- and community-based cases to ensure consistency. In other areas it was acknowledged that the hospital-based team *may* accept referrals that would not be accepted by the local authority's community-based team, but this was seen as appropriate multi-agency decision-making
- access to multi-disciplinary approaches and community support. There were concerns about cases referred to hospital-based teams not having the same access to multi-agency assessment and community-based support. One local authority had moved away from having a hospital-based team in part because of concerns that hospital-based cases were not getting the full core offer of family support, instead being held for too long by the social work team pre-referral and then moving quickly to court proceedings once the referral had been made. In another trust the participant thought that having a social work team on site might be resulting in less use of early intervention and community support in some cases

*'The potential disadvantages are [hospital] teams can become slightly out of the loop of the mainstream of county practice and you have to work harder to make sure there is consistency. There is a danger of becoming a little bit of a closed world .... The advantage of having it dealt through the mainstream is that you also have the benefit of services based around the geography of where the child lives and you're keying into local services and potentially a much more holistic approach to meeting the child's needs rather than indexing the incident that led to them being in hospital .... At some point hospital teams usually pass over to a mainstream team so you're potentially reducing the number of changes of worker for the child and family.'* Local authority, community-based social work service.

On the other hand, the strength of multi-agency relationships between social work and health in in-hospital set-ups was acknowledged. It was also said that hospitals with a social work team on-site can become the base for multi-agency work, with police and other agencies coming to the hospital for multi-agency meetings

- clarity about what information has been shared, whether a referral has been made and what decisions have been taken. There was concern that more informal 'on the move' communication could lead to a blurring of decisions and more explicit roles and communication were better. Hospital social work teams stressed that their discussions and interactions were generally with senior staff

and were documented, and that this informal interaction had not led to problems.

Overall, close working relationships and high levels of interaction between social work and trust staff were described in all the case study sites with hospital-based social work teams, but there was more variation among the community-based teams. Some sites with community-based social work teams described levels of interaction and quality of relationships, which seemed at least equal to those described in areas with in-hospital teams. Others described less, and some very little, joint work and interaction particularly outside the context of individual cases.

What the data highlight is that both in-hospital and community-based arrangements can be effective bases for joint working, and that no individual model is automatically privileged. It is worth noting too that there were not clear differences between local authorities and trusts in their preferences for and views about models. Where a hospital team was in place this was strongly endorsed as the right model by both trust and local authority. In areas with community-based arrangements, generally neither trust nor local authority saw a hospital-based model as preferable. However in two areas where a hospital-based model had been withdrawn, this was seen as detrimental by the trust but not by the local authority.

The case study data suggest that for hospital-based teams to work effectively there needs to be:

- clear joint responsibility on the part of the local authority and trust for safeguarding, with the trust not becoming over-reliant on the local authority for action and decision-making
- clarity about the scope of work of the social work team and the respective roles of the trust and local authority in information collection
- sufficient capacity for the local authority team to add value
- respect by the trust for social work input so that social workers' involvement is welcomed
- strong local management of the social work team
- good links (at managerial and practitioner levels) with central social care departments with approaches for checking and ensuring consistency in decision-making and service provision.

For community-based teams to work effectively, the data suggest there needs to be:

- clear mechanisms for regular and active interaction, both formal and informal and at strategic and operational levels, between the trust and the local authority
- named link people within each agency who lead on liaison and coordination

- an understanding of trust and local authority operating contexts, respect for and positive desire to engage each other's expertise
- social work staff available to give advice and come to the hospital at short notice
- a recognition that relationships may be harder to build and sustain without co-location and willingness to make people available, both to deal with individual cases and to be involved in wider development of joint processes, to mitigate this.

These issues are explored further in the rest of this report.

## Hospital safeguarding staffing arrangements

The precise make-up of safeguarding units or teams in acute trusts involved in case studies varied, but they generally involved a Named Doctor, Nurse and Midwife (although some posts were vacant or combined), specialist child protection or safeguarding nurses or advisors, administrative support, and sometimes also training support. Many case study maternity services had specialist midwife posts leading casework for vulnerable women (or with specific specialisms in eg substance misuse, mental health, learning difficulty, teenage pregnancy and, in one case, a perineal midwife who led on cases involving female genital mutilation). Some sites also had a Paediatric Liaison Health Visitor or Nurse. This was seen as a key role, ensuring that cases involving potential child maltreatment were brought to the attention of the safeguarding team and gathering information particularly from community health professionals (GPs, health visitors and school nurses).

Some sites also described formal or informal lead roles for safeguarding for ward-based staff. All the case study sites had 24/7 access to consultant paediatricians or paediatric registrars. In the acute trust survey, high levels of access to staff with clinical expertise was described for staff dealing with cases involving possible child maltreatment – see further information in Section 3.1.

The work of safeguarding teams involved providing informal advice to clinicians; gathering information from within and beyond the trust in cases where there was a concern about possible child maltreatment; liaison with social care; audits, training, development and implementation of policy and procedures; attending case-specific meetings such as strategy meetings and case conferences with or in place of clinical staff; attending psychosocial or other meetings to review cases, and strategic work including Board liaison. Training was given particular emphasis, and meeting (or exceeding) the safeguarding training requirements for trust staff – as set out in the intercollegiate document *Safeguarding Children and Young People: roles and competences for health care staff* (RCPCH, 2010) – was seen by both trust and local authority informants as an important way in which trusts had moved safeguarding practice forward. Sustaining awareness of the central importance of child protection within the trust, through being seen on wards and being available, was seen as important.

Local authority staff in the case study areas were extremely positive about the work of safeguarding teams and particularly of Named Nurses (and there were also positive comments about safeguarding teams in open-ended questions in the local authority survey). Individual trust staff were seen as having had profound impacts on practice at strategic and operational levels. There was occasionally concern that a trust was over-reliant on one or two key individuals. As we noted earlier, there were no obvious differences between case study sites with in-hospital or community-based social work teams in the scale and nature of the work done by the trust safeguarding team, and no indication that trust safeguarding staff were less active in trusts with an in-hospital social work team.

**Call for Practice example: Specialist Nurse for Safeguarding Children and Young People (Acute Services). Submitted by: Cardiff and Vale University Health Board**

The Specialist Nurse oversees and supervises child protection cases from admission to discharge, working directly with the child, family and partner agencies. They ensure policies are adhered to and that quick and effective liaison takes place, they support families in understanding the processes, help partner agencies to understand the medical issues and ensure a multi-agency strategy meeting is convened. The system provides a single point of contact for the local authority and for other health staff, and the role has been recommended in serious case reviews and by the Health Inspectorate Wales. Cardiff and Vale say it has improved information sharing, multi-agency planning and children's outcomes.

## Identifying cases where child maltreatment needs to be considered

This chapter looks at how trusts identify cases where child maltreatment needs to be considered and the role of social care information in this. It is useful to note for context that, since this study, the Department of Health has confirmed the planned roll-out of the 'Child Protection - Information System' in NHS hospitals from January 2015. Development of this system will begin in 2013 and the aim is to provide healthcare professionals working in EDs or urgent care centres with ready access to data that indicates whether a child is already 'at risk' or potentially being maltreated (Department of Health, 2012).

All the case study trusts operated triage systems involving consultation with senior ward staff, notification to the safeguarding team of cases often using Cause for Concern forms, and referral to social care.

## Identifying cases where child maltreatment needs to be considered

### Confidence about identification

These trusts had a range of approaches for identifying the cases where child maltreatment needs to be considered. Overall they were generally confident about practice in their trust, seeing little evidence to suggest cases were regularly being missed – rising numbers of cases were being raised or referred, and there was little or no evidence that this was happening later than it should have. However they acknowledged that they could not be sure all appropriate cases are identified: *'you don't know what you aren't seeing'*. Local authorities too were generally positive about trusts' ability to identify cases, although there were references to occasional late referral and concern that the sometimes-poor quality of referral information (see Section 4.5 for further information) might imply superficial investigation or questioning.

Since known missed cases were rare it was difficult for participants to discern a pattern, but the issues which were seen to raise some challenges were:

- issues that were less obvious, social problems that lay behind the presentation issue, and chronic low-level problems and neglect: midwifery participants noted that post-natal home visits are sometimes *'a real eye-opener'* raising concerns that had not previously been apparent
- neglect – in the form of poor supervision – being missed where a child presents with an injury arising from, for example, a fall
- clinicians being too trusting of parents, taking their explanation for an injury at face value
- maternity services focusing on the mother's needs without enough critical appraisal of what this means for the unborn child and a tendency towards *'false'*

*optimism*', where for example the mother's engagement with substance abuse services distracts from the continued risk to the child

- self-harming or substance misuse by adolescents not being recognised as potential safeguarding issues
- issues missed by new staff, staff with less paediatric expertise and those who were less skilful in their dealings with children and parents.

Individual cases had also sometimes been missed because of problems with record systems:

- glitches in access to information about social care contact (see Section 3.2 for further information)
- poor information sharing between acute and community services
- repeat attendance not being sufficiently obvious in ED records – for example a record card which shows the number of attendances, whereas having access to the full set of notes would be a much stronger visual cue about repeat attendance
- a lack of information-sharing between a mother's notes and her baby's, with child protection information in the mother's notes only
- differences in the surnames of siblings or parents and children, meaning connections were not made between attendances by members of the same family.

### **Supporting comprehensive identification**

Identification was supported by training and awareness-raising; the use of checklists, assessments or standardised information collection; specialist staff, and information from social care.

Training and awareness raising was a key part of the work of Named staff for child protection, and some said they saw an immediate increase in referrals from newly trained cohorts of staff or wards. Publicity on wards – copies of flowcharts, and posters highlighting the importance of considering particular types of issues – were used to support this. Several trust participants said that their training encourages clinicians to think widely about a child's needs, development and wellbeing and to look at what might lie behind the presentation issue.

*'I'm very confident about [identifying chronic neglect], we get a lot of neglect referrals here including from ED .... We train them to look at the child in all of those terms and they have lists of what to look for in the four categories of abuse .... We always ask them to look at the parent-child interaction .... They're very good at referring if they feel the child is not making eye contact with the adult carer or parent, or feeling frightened .... Any adolescent if they've self-harmed or overdosed on alcohol or substances, they*

*are automatically admitted for a full paediatric review and psychiatric review .... There's a real focus here and always has been ... on looking at the child and their behaviours and what's behind the behaviour. It's a little hobby horse of ours here, it's terribly important to look at that and staff here are very good at talking to the child alone.'*

Acute trust, hospital-based social work team

Looking first at EDs, most of the case study sites used some form of structured approach to gathering and/or analysing information, and sometimes several in combination, to identify cases where child maltreatment should be considered. These were flowcharts, cover sheets, risk assessment schedules or checklists or other structured approaches to taking history, identifying issues and making decisions about next steps. There was some debate about their value. They were felt to be helpful, particularly given the speed of patient throughput in EDs to keep clinicians conscious of issues, to support consistently full investigation and for less experienced staff in particular, and some trusts reported that notifications and referrals had risen after their introduction. Structured approaches were used less by midwives as we discuss below.

A heavy emphasis was placed on the fact that checklists and other structured approaches are there to support, not replace, clinical judgement, that they need to be used in a meaningful and *'not tick-boxy'* way as part of a detailed inquiry, and that clinicians need to be trained on how to use them well. There were concerns that clinicians rely too much on an earlier professional's assessment – in one trust, for example, an audit had highlighted that doctors' recording of child protection issues was more limited if a nurse had documented an initial assessment of child protection risks. There was concern they may produce a kind of *'white noise'*, which dampens rather than heightens attention to child maltreatment. One Named Nurse noted that research and local audits showed the use of checklists made no difference to the actual identification of at risk cases and the trust was therefore rolling back their use. In other trusts the decision had been made not to introduce them because of concerns they deflect from professional judgement and focusing on the child. Elsewhere they were viewed as a helpful support to clinical expertise, although this judgement did not appear to be based on rigorous testing of their use and impact on identification and action.

*'We have a type of checklist in children's A&E notes where staff are asked to consider previous attendances, to check them, if the injury matches the mechanism of injury and various other questions like that which they complete for all children ... a reminder, I suppose. I think personally it is very useful .... I think staff find it a bit tedious but it's important .... I think it helps them to think about things and to ... consider safeguarding issues with all children.'*

Acute trust, community-based social work service.

*'It's left to professional judgement really because I think there's potentially a danger of being so prescriptive, if they don't tick a box people stop looking outside the box .... We have enough training within the trust and enough [people trained] to prevent them missing things.'*

Acute trust, community-based social work service.

Where they were used, these instruments varied in their breadth, but across the piece they covered:

- the nature or cause of harm: identifying for example potential non-accidental or other worrying injury, assault, abuse, bullying, gang crime, self-harming, risk behaviour including substance misuse, head injury, knife injury, burns, fractures, dog bites
- issues relating to presentation behaviour: delay in presentation, inconsistency in story, unusual parent-child interaction, the child's demeanour, presentation without a parent or with another adult, repeat attendance
- wider child wellbeing issues: having a social worker, home schooling, concerns about child's development or general appearance, parental substance misuse or mental health, domestic violence, other family needs or concerning issues
- and in maternity services: social work involvement, unwanted or concealed pregnancy, non-attendance, domestic violence, substance abuse, mental health problems, homelessness, learning disability and experience in care.

There were differences between trusts in whether the screening procedure was routinely used on all children or with clinical selection. Some areas had protocols for automatic referral to a senior clinician, the safeguarding team or specialist midwives, or social care if particular risk factors were identified.

Most systems had been designed within the trust, but one area used CWILTED<sup>8</sup> and two were considering the Graded Care Profile<sup>9</sup>. One local authority participant described a current project coordinated by the Local Safeguarding Children Board (LSCB) to identify an agreed set of models to be used across local agencies, and in another area the trust and local authority were jointly developing an antenatal assessment to be used by social work staff, midwives and health visitors. Other trusts did not appear to have developed their approaches in collaboration with the local authority, and local authority informants had varying degrees of knowledge about them.

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<sup>8</sup> CWILTED is a mnemonic which encourages consideration of: Condition (the injury or presentation that suggests a child protection issue); Witness (who was with the child at the time); Incident (the mechanism for the injury or harm); Location (of the incident); Time (of the incident); Escort (who is with the child in the emergency department) and Description (the child's behaviour and appearance) sometimes replaced with Disability (Willis, 2001)

<sup>9</sup> The Graded Care Profile uses a five-point scale across items in four domains: physical, safety, love and esteem (Srivastava and Polnay, 1997; see also Barlow et al, 2012)

These structured approaches were less frequently used in maternity departments in the case study areas. Some areas were using flowcharts or risk assessment approaches, again usually developed within the trust although some referred to the Perinatal Institute<sup>10</sup> records system. In others, the view was that midwives' attention to social welfare issues and risks to unborn children was strong and their engagement with women more prolonged and intensive so that checklists were not necessary or helpful.

Finally, trust participants also described a growing focus on identifying child protection issues through adult ED attendance, and several said that referrals from adult EDs were rising – and were previously non-existent. Domestic violence had been a particular area of increased vigilance and rising referrals. There had been more focus on training, raising the profile of children and developing pathways in adult services. Some trusts felt staff in adult services particularly ED were now very vigilant; others still found it hard to engage clinicians in spending time and developing skilled approaches to questioning. In some trusts there was now a policy of routinely asking all adults presenting in the adult ED whether they are responsible for dependents (with varying degrees of confidence about how systematically this is done). In others this was asked where the presentation raised a potential child welfare issue, such as domestic violence, mental health or substance abuse.

*'Staff [in adult ED dealing with domestic abuse] will always assess to see if there are children within that household, and if they were present at the time; and they will have that discussion with social care colleagues and that's moved on quite a lot because before it was done in isolation so we could have an adult attend for a domestic abuse issue and they would purely deal with that adult and there wouldn't be the consideration of children. However now staff do think about are there children .... It's the same process ... if they see an adult with alcohol misuse or significant mental health difficulties, self-harming, or intentional overdose or recreational drug use, again they consider the family as a whole, are there children, where are they.'*

Acute trust, community-based social work service.

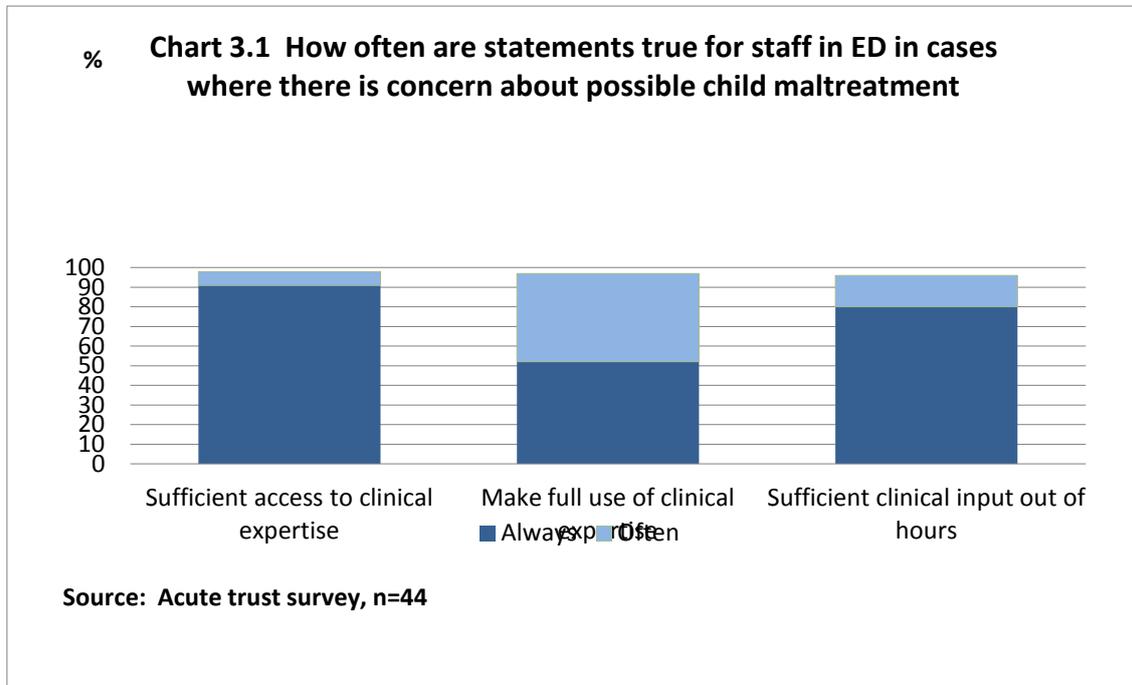
### **Access to clinical expertise in cases involving potential child maltreatment**

The case study acute trusts had protocols or working practices for senior clinical staff – paediatric consultants or registrars, lead child protection consultants and specialist midwives – to be involved in the assessment of cases where child maltreatment was considered, and said that there were rarely difficulties in getting this input. Similarly, trust survey participants reported high levels of access to clinical expertise for staff in ED in cases where child maltreatment is considered. Almost all (91%) reported that staff in the ED always have sufficient access to relevant clinical expertise from other hospital staff in cases where child maltreatment is considered, although only half reported that

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<sup>10</sup> The NHS Perinatal Institute has developed a set of records which, at the antenatal stage, include consideration of social as well as medical risk factors <http://www.preg.info/Default.aspx>

staff always make full use of this expertise. Eighty per cent said staff can always get sufficient input from all the necessary clinical staff out of hours.



## Information collection and sharing

### Information-sharing: general approaches

Gathering information was an important part of the process of identifying cases of concern and establishing the level of concern, and an important activity in cases where concern had been established. Trust staff described gathering information from, and sharing information with:

- the clinicians immediately involved in the case: to ensure they had a rounded picture of the child's attendance and the investigation of concerns
- clinicians likely to be involved in the future: particularly in maternity services cases, where information would be shared for example with the labour ward and neonatal unit
- other immediate team members: either the safeguarding team or the midwifery team
- social care: since this was a key focus of the research, information sharing with social care is discussed in detail in the section below
- community health professionals and services: particularly school nurses, health visitors, GPs and community midwives. References were sometimes also made to liaising with mental health services, substance misuse services and community child health services

- police
- there were also some references to liaison with education (teachers and education welfare officers) and with other community services (domestic violence services, Children’s Centres and housing services).

This activity happened before, alongside and after referrals to social care, and also in cases where a referral was not made. Regular team meetings – safeguarding meetings reviewing Cause for Concern cases, psychosocial or ward meetings (see Section 5.1 for further information) – were important for information sharing and for updating. Some trusts also described Cause for Concern forms routinely being copied to school nurses, GPs and health visitors.

There appeared to be some different emphases in the way information-sharing was discussed by the case study trust participants. There was variation in:

- how extensively information was described as being gathered and shared (ie the range of professionals and agencies mentioned)
- how far information-sharing was described by the participant as a core part of their role
- the emphasis placed on *giving* information *to* other agencies or professionals compared with *gathering* information *from* them
- the relative emphasis on information-gathering to inform the decision whether or not to refer, or information-gathering as part of continuing casework post-referral
- and the emphasis placed on referring or signposting patients to other professionals and agencies or engaging with services to get support for the patient, rather than just passing on information to professionals and agencies.

Some case study trust participants noted that the interface between acute and community health services is challenging, including in integrated trusts, so that information-sharing is not always easy.

There was also some discussion of the role of the Common Assessment Framework (CAF<sup>11</sup>) in information-sharing (we discuss its role in the referral process in Section 4.1). Both trust and local authority informants said that it is difficult for acute trust staff to engage with the CAF process because of the turnover of their work and their often-limited engagement with patients. CAFs were rarely done at all by acute trust staff except in cases where trust staff were very involved in the case, for example a child with

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<sup>11</sup> The Common Assessment Framework is a standardised approach to assessing children’s additional needs beyond universal services and planning how to meet them, intended to be a key part of early, holistic and coordinated support for children and young people. It is not intended to replace or delay referral to children’s social care where children are at risk of severe harm. The standardised document on the Department for Education website <http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf> is 11 pages long including space to document actions and review.

complex health needs or a complex pre-birth case. Some local authorities said they would like to see some form of CAF being used more by trust staff, noting that it ensures better information sharing, makes it easier to provide the right input in cases not meeting the threshold for child protection action, and led to fewer re-referrals. Some trust participants, too, felt that the trust's engagement with community services needed to be strengthened, particularly given increased focus on early intervention, although they saw this as challenging.

### **Information sharing: social care**

#### *Accessing information about social work involvement*

Information about previous or current social work involvement was an important part of identifying cases of concern and assessing the level of concern.

In the acute trust survey, 57% of trusts said the local authority they work with most often provides a regularly updated list of the names of children who are the subject of a Child Protection Plan (CPP); 43% of trusts said this was not happening. Almost all the case study areas received this information, with varying degrees of regularity from twice-weekly to monthly, sometimes with interim updates. One trust received a copy of each new CPP as it was made; two trusts had electronic access to plans. Some trusts had had to press hard over a long period of time to get access to a list or reported that issues concerning access, or administrative support to manage the information, had not yet been resolved.

In the case studies, participants described the names of children presenting in ED being checked against the list of children with CPPs (either a paper copy on the ward, or a check made via the safeguarding team or social care). This was occasionally done routinely, and more often only if there were concerns. In the case study maternity departments, having access to information about CPPs meant that in some areas a CPP relating to an older child or an unborn child would be known at the booking-in appointment. But most areas depended on midwives checking the CPP list only if they had concerns about a pregnant woman or relying on her telling them about previous social work involvement. Some were concerned about this potential for information to be missed.

Trusts also proactively sought information about whether children are the subject of a CPP or otherwise known to social care by direct approach to the social work team (either based at the hospital or in the community). The acute trust survey found that all the trusts involved were able to contact social care to find out if a child is already known to them – almost all with 24-hour telephone access but one with telephone access during working hours only and one with direct online access. One-third of trusts in the survey (32%) said they routinely checked whether a child was known to social care and two-thirds (66%) that they did so on some children only. Case study areas reported routinely asking children and pregnant women whether they had a social worker<sup>12</sup> and seeking this information direct from social care in cases when they had concerns.

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<sup>12</sup> None of the case study areas described routinely checking with social care whether children were known to social care, and said this would be an overwhelming volume of work. It therefore seems likely that all or most of the trusts

Where the approach about social work involvement was made to the hospital-based social work team, it was generally said by case study participants to run smoothly. However, where the approach was to a community-based team or an out of hours service it could be problematic. In the trust survey, whereas 80% of participants said that ED staff can always get sufficient input from all the necessary clinical staff out of hours in cases where child maltreatment is considered (see Chart 3.1), only 34% said they can always get sufficient input from social care out of hours. Trust case study participants described being challenged as to why they need the information and having to '*present your credentials*' repeatedly and sometimes having to be '*very assertive*' about needing information. They also described out of hours services requiring a message to be left and the call not always being returned, and not always being able to ascertain whether the child is known to social care if they do not have a CPP.

Local authority case study participants, on the other hand, said it was right that their staff should check credentials before giving out sensitive information. They said it was appropriate that clinicians should be asked to explain their concern about possible child maltreatment, both because of the importance of this being shared with social care and to discourage '*fishing exercises*' where information about social work involvement was being sought but where there was no obvious cause for concern.

#### *Flagging information about social work involvement*

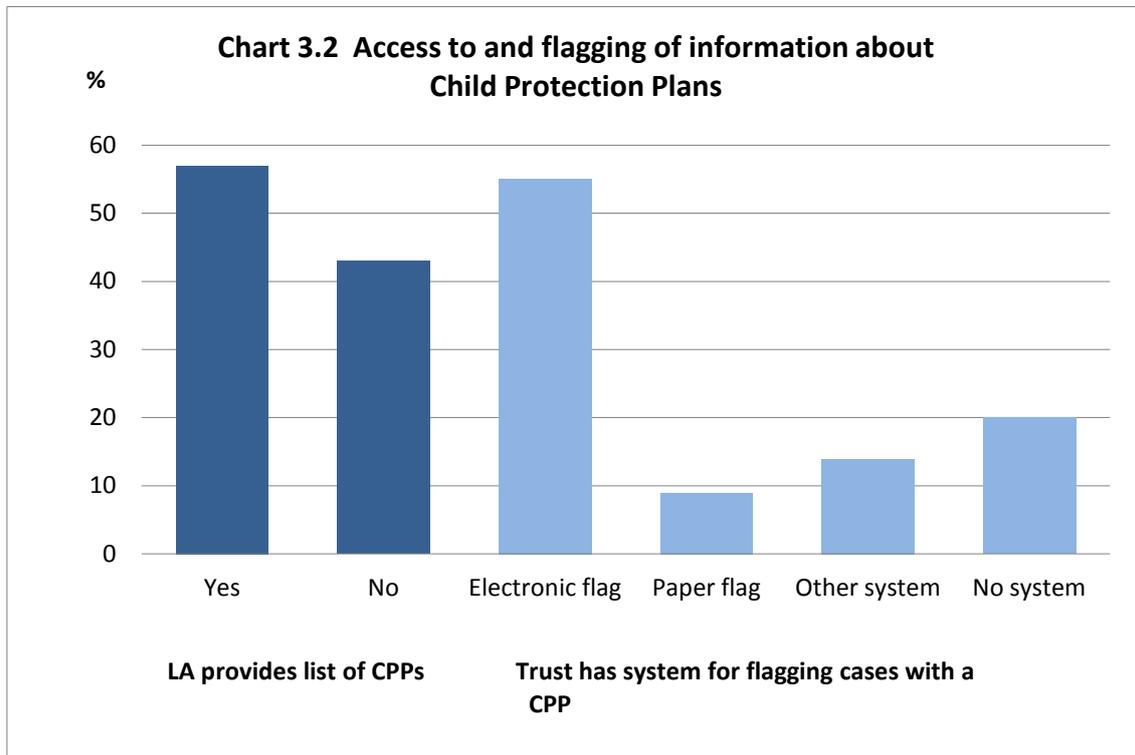
The acute trust survey identified that 78%<sup>13</sup> of trusts have a system for flagging cases where the child is known to have a CPP, mostly electronic (55% of trusts) and sometimes paper-based (9%) or another system (14%). Twenty per cent reported that they do not have a system in place for flagging cases where the child is known to have a CPP. In 59% of trusts the system operates across the whole trust; in 24% it operates in the ED and at least one other department but not in the whole trust, and in 15% it operates within the ED only.

Case study participants described a combination of electronic alerts and coloured inserts in paper records. Electronic record keeping systems sometimes placed constraints on how flags could be used or how visible they were. Only one trust described having audited its ED alerts against local authority records to test whether cases were being missed or wrongly included. Two trusts also described setting up a dummy record for children with CPPs who have never attended the hospital and so do not have a hospital record, so that if they attend the CPP alert would be in place. One trust informant said the system of setting up a dummy record card for a child with a CPP could not be used for unborn babies, and the information could not be recorded in the mother's record because of data protection issues. There were also difficulties in sharing or transferring information between the mother and baby's records. One case study trust also described flagging victims of domestic violence who were the subject of Multi-Agency Risk Assessment Conferences (MARACs).

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reporting this as a routine check in the survey were referring to seeking the information from patients, rather than from social care.

<sup>13</sup> This is a higher proportion than those receiving a list because trusts also identify CPPs through direct inquiry to the local authority



Source: Acute trust survey, n=44

#### *The value of information about social work active cases*

As with the use of standardised risk assessment instruments, both local authority and trust case study participants emphasised the importance of using information about whether a child had a CPP or was known to social care as an addition to a full clinical assessment of cases and in-depth information collection, and to step the level of concern up but not down. In this context it was felt to be an important part of information sharing.

*'I think it's just an extra level of alertness, and what we do want is we want our allocated social workers to know that a child's been taken to A&E .... They should have greater attention, they're our most vulnerable children. I have no evidence that they're using [the existence of] a plan as a screening tool.'*

Local authority hospital liaison team.

*'I think in A&E it's important to risk assess, whether there's a plan or not. I think it's important if they're on a plan to have that information because I think that's very relevant and you could be holding the last piece of the jigsaw .... As long as it doesn't blur [your assessment]. Sometimes you could flick through ... the child protection register and you're going 'no he's not on' and you're forgetting that the child in front of you might be the one that needs to be on.'*

Acute trust, hospital liaison team.

It was also said that knowing about social work involvement in cases where the child did not have a CPP was very important, and that these inquiries sometimes yield extremely valuable information. This was seen as important especially in complex cases where information given by the family raises suspicions but there are not clear grounds for a challenge. Knowing more about the family might reinforce a clinician's concerns or might directly question something the child or family had said, giving a much more secure basis from which to have what was likely to be a challenging conversation with the family.

But there were real concerns that knowing a child is not on a CPP or known to social care can lead to false confidence or dismissal of evidence of possible child maltreatment, and that knowing a child is on a plan for a particular type of maltreatment might lead to dismissal of concerns about another type. It was also noted that the CPP list is out of date as soon as it is received (a particular concern for those receiving it with lower frequently and without interim updates), that there may be gaps or glitches in transferring the information on to hospital record systems, and that if the trust also sees children from local authorities which do not share a list of CPPs it is difficult to devise a watertight approach. This reinforced their emphasis on the importance of clinical assessment and a holistic investigation of the child's wellbeing.

*'We have to act on the presenting issue and if it's in any way concerning it would be dealt with no differently, whether or not the child has a plan .... It's probably more likely to be the other way where they see the child isn't subject to a plan and they aren't as concerned as they should be, it possibly reassures where it shouldn't.'*

Acute trust, hospital-based social work team.

These issues had led some trusts to opt not to receive lists of children with CPPs, relying instead on clinicians' assessment and on a direct approach to social care where information about their involvement was needed. One trust's audit had shown that knowing about a CPP did not impact on clinicians' behaviour (although knowing the child had a social worker did), but other trusts did not appear to have monitored whether having access to a list of CPPs actually leads to better identification and referral.

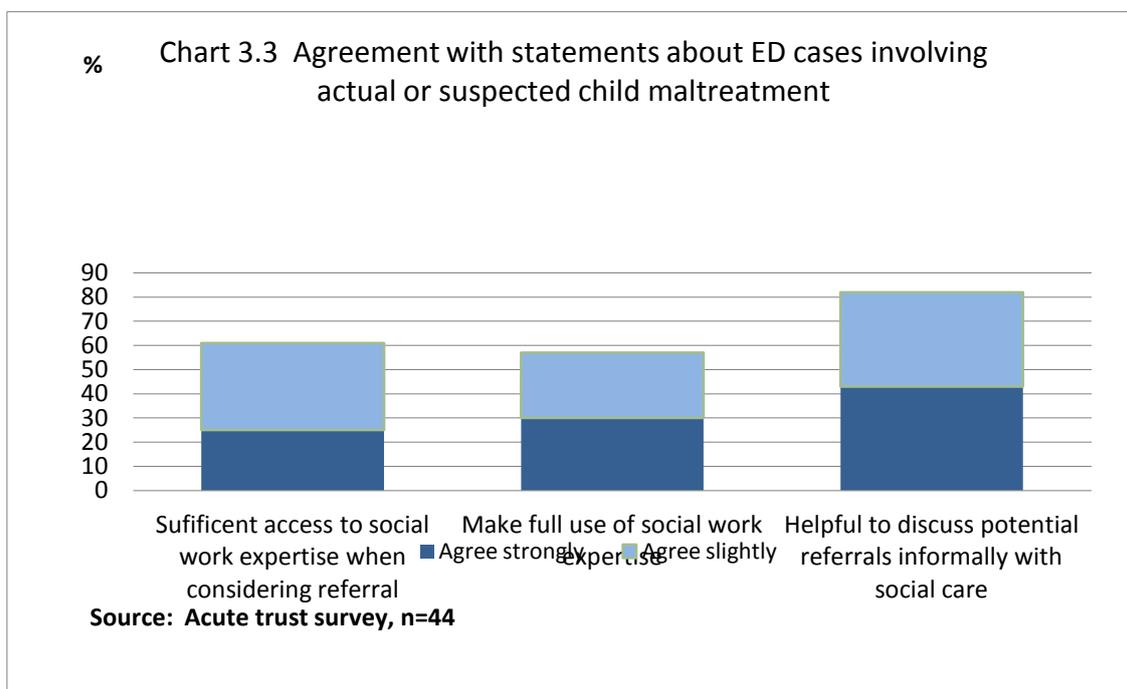
Finally the importance of sharing information *with* social care, as well as gathering information *from* social care, was emphasised by case study participants. If the child had a CPP, both trust and local authority staff underlined the importance of social care being alerted to a hospital attendance that had led to concerns. Some participants also stressed the importance of social care knowing about attendances that had not caused concerns, so that the family's positive engagement with services could be noted. Where children do not have a CPP, both trust and local authority staff saw it as important that social care should be able to note an accumulation of concerns about a particular child or family.

## Making the decision to refer to social care

The acute trust survey found that 64% of trust respondents agreed strongly with the statement 'I am confident staff know which cases to refer to children's social care', and 34% agreed slightly. We noted in Section 3.1 that trust survey participants were generally positive about access to clinical expertise in cases where child maltreatment was considered. The case study acute trusts also described having protocols or working practices for senior clinical staff – paediatric consultants or registrars, lead child protection consultants and specialist midwives – to be involved in, or to sign off, the decision to refer to social care. These staff were then also involved in subsequent case management, attending strategy meetings and pre-discharge meetings.

Safeguarding staff, particularly Named Nurses and Midwives, were also involved in decision-making, although in urgent or clear cut cases clinicians might refer directly to social care without, at that stage, involving safeguarding staff. Generally though safeguarding teams played an important role in advising on options and strategies and collecting information from within the trust and more widely. In some trusts this was a very involved role with the safeguarding team essentially case managing, doing the information gathering and multi-agency liaison and typically seeing the child: in others it was more about supporting the lead clinician.

The acute trust survey showed perhaps surprising low levels of access to social care expertise when decisions are made about whether or not to make a referral to social care. As Chart 3.3 shows, only 25% of acute trust survey participants agreed strongly that hospital staff have sufficient access to social work expertise when they are considering making a referral, and 36% agreed slightly. Similarly, only 30% agreed strongly that staff make full use of social work expertise when they are considering making a referral, and 27% agreed slightly. In fact there was not a particularly strong endorsement of involving social care in the decision: under half, only 43%, agreed strongly that it is helpful if staff discuss potential referrals informally with social work staff before making a decision, and 39% agreed slightly.



The case studies also found varying degrees of involvement of social care staff in pre-referral activity but the general picture was one of more use of this than the survey data showed. Hospital-based social work teams were particularly involved, providing advice and discussing options, sharing information collection and liaison both before and after the referral was made. They saw this as a very important part of their role, and a key element of developing joint working practices. Their work was carried out alongside safeguarding teams, meaning that clinical staff could go to either group for informal advice about making a referral and that the two teams worked closely together. In these areas, neither the trust nor the local authority team felt these arrangements were problematic or created confusion, or suggested too much reliance on the social work team.

In trusts where the social work service was community-based the picture was a little more mixed. All the local authorities provided a consultation service to give advice pre-referral, and some trusts and local authorities again described a lot of interaction in the decision whether or not to refer, finding this very valuable and a mark of their mutual openness and commitment to joint working. Others described much less, or virtually no, informal advice being sought from the local authority. In some areas it was felt appropriate, by both the trust and the local authority, that clinicians should access advice within the trust and only from the local authority in rare cases. In other areas however there was a view that more informal discussion would help to improve referral practice and joint work. It was thought not to happen because of a lack of confidence in the local authority's threshold or an unwillingness on the part of the trust to consider other options for cases below the threshold level, passing this responsibility to social care.

*'Yes, staff are quite happy to do that as well [as get advice from hospital staff] and the flow chart does promote that they're able to have those conversations .... About three years ago staff were more hesitant to have that informal conversation and I think local authority and social care colleagues were perhaps more reluctant too .... There was a lack of confidence [among trust staff] in dealing with safeguarding issues .... We've worked really hard at increasing that level of confidence.'*

Acute trust, community-based social work service.

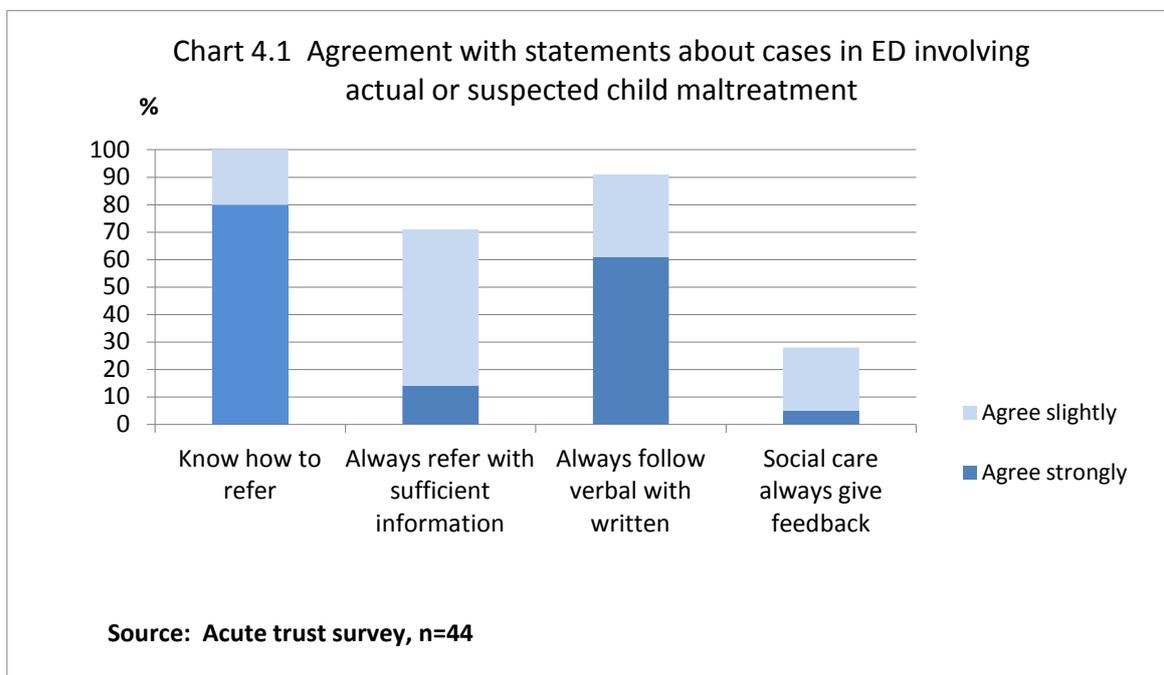
*'I don't think there's that relationship as yet that we feel like they're on our side. It's still a bit [like] we make the referral and we wait to see what they come up with and then see if we agree or if we're going to challenge it.'*

Acute trust, community-based social work service.

## The referral process, response and subsequent work

### The referral process

The acute trust survey showed high levels of confidence that trust staff know how to refer: 80% of trust respondents agreed strongly that staff know how to refer to social care in ED cases involving actual or suspected child maltreatment. There were more issues with aspects of the referral process and feedback, as Chart 4.1 shows and as we discuss further below.



In almost all the case study areas, referrals were said to be primarily made by frontline clinicians. This was seen, by both trust and local authority staff, as very important for a number of reasons. It was felt most useful for the referral to be made by the person who saw the child, spoke to the family, took the history and so had the most direct and full knowledge of the case and why it was causing concern. It was also seen as important for making speedy referrals, without undue delay. It was seen as a marker of the fact that safeguarding is the business of all trust staff, and important for building confidence and knowledge about safeguarding among clinicians. And finally the volume of cases meant that few safeguarding teams felt it was feasible for them to make the referral.

In two case study trusts, however, the system was different, with the safeguarding team doing all referrals in one and most of the maternity service referrals in the other, except out of hours or in urgent cases. They had considered other approaches carefully but concluded that this was the safest way of ensuring that referrals were done well and –

most importantly – that they could follow up and engage with the response: *'The model is labour intensive but it's safe.'*

Referrals were made either to the hospital-based team or to a central access point, by telephone or by a personal visit to the hospital-based team in urgent cases, by email if there was a secure email channel, by fax, or by documentation being taken to or collected by the hospital-based team. Some case study trusts had a policy of always telephoning to make or alert social care to the referral. Not having a secure email connection was a cause of frustration. If the local authority did not routinely acknowledge receipt of referrals made by fax, and the trust did not routinely follow up, a communication failure could go unnoticed and a referral not be made – although none of the case study informants described instances where this was known to have happened.

Out of hours, referrals were made to the emergency duty team although if the child had been admitted, trusts with hospital social work teams sometimes waited until the hospital team was available. In one area the trust informant said the duty team was reluctant to accept referrals in the hours before 9.00am, instead asking the trust to wait until the hospital-based team was available, which caused problems since these were often urgent cases. Comments made in the survey in response to an open-ended question suggest that other trusts find the out of hours referral process more difficult than during office hours, with some reports of difficulties in making contact or getting a response.

As Chart 4.1 shows, 61% of trust survey participants agreed strongly that trust staff always follow up verbal referrals with a written referral, and 30% agree slightly.

This was recognised everywhere in the case studies as important, to ensure information-giving was clear and to provide a mandate for the social work team to take what might be very invasive action. Although a written referral was routinely provided in a timely way in some areas, in others the local authorities had to chase.

As Section 3.2 noted, trust staff rarely complete CAFs, and none of the case study local authorities require a CAF or an e-CAF or mini-CAF as part of the referral process. Case study participants from local authorities and trusts routinely said it was much more important that a referral should be done without delay. Occasionally trusts said that CAFs were required by other (non-case study) local authorities and found this problematic, acting as a barrier to the child protection service. One trust informant understood that a requirement for a CAF was being introduced by the case study informant and was very concerned about how this would work in practice.

All the case study trusts worked across more than one local authority, and some said that fewer than half of their child patients come from the local authority they work with most. This meant that acute trust staff needed to work with different referral forms and processes, and with different local authority thresholds for accepting a referral. For some this was not particularly problematic, but others found it an added challenge, and the support provided by hospital-based social work teams was greatly appreciated and missed if it was no longer available.

## Consent to information sharing

An issue raised by some case study local authorities, and some trusts, was that clinicians did not consistently inform the family that a referral was being made or seek their consent to information-sharing. This was felt to be an essential practice unless it would compromise the child's safety or if the decision to refer or share information was made only after the family had left the hospital. It was seen as providing an important mandate for action, and not having done it created real difficulties in securing the family's engagement when social care followed up the referral.

In some case study areas both the local authority and the trust were confident that it would be in rare cases only that clinicians failed to inform the family or seek consent: these rare cases had led to immediate discussion with the clinician and were recognised as an important failure in practice. More often, though, it was seen as an area where practice still needed to improve and where training and support was needed for clinicians to develop confidence and skills in managing this interaction. In some areas there was a sense of more resistance – trust informants were less convinced of the need to seek consent, or local authority staff reported '*vociferous conversations*' with trust staff which were thought to display differences in wider organisational cultures around the importance of partnership work with families.

## Pre-birth referrals

There were also differences between case study local authorities at the point at which they accepted pre-birth referrals, although in several areas practice had recently changed or was under review. Some trusts, and some local authorities, reported a reluctance to accept referrals before the pregnancy was viable, with the cut-off date varying from 16 weeks to 24 weeks. In other areas referrals were accepted as early as eight weeks. Trust participants emphasised that pre-birth planning takes time and plans need to be in place well before the due date, because of the frequency of early births. Local authority participants also noted that early referral was important so that parents have support and opportunities to show whether they can address potential child protection concerns. Agreeing processes for referral at the right point was the subject of continuing joint work in some areas, and in others the trust remained concerned that local authority planning was too slow or began too late.

**Call for Practice example: Joint working protocol between maternity services and children's social care. Submitted by: Southampton Foundation Trust**

The protocol provides an agreed process between health and children's social care on the planning, assessment and actions required for safeguarding unborn children, emphasising the importance of early intervention and information sharing. It sets out the key concerns that trigger the protocol, the need for an early professionals' meeting, the circumstances that should automatically trigger a referral to social care, the need to refer as soon as concerns have been identified and the factors to consider in undertaking a pre-birth risk assessment. The midwifery practitioner who attends the initial child protection conference is responsible for ensuring a safeguarding birth plan is agreed by 34 weeks gestation, whether or not there is a child protection plan, with clear directions for delivery and the post-natal period. The protocol sets out responsibility for ensuring other professionals are aware of the plan. If there is no discharge plan within the birth plan, a discharge planning meeting or discussion should be held.

Southampton report that the protocol has improved communication between the two agencies, and that pre-birth assessment and planning are done in a more timely way.

## Referral quality: timeliness

Both local authority and trust informants in the case studies reported there was rarely evidence of delay in referrals being made. Trust safeguarding staff said they occasionally picked up cases through other scrutiny arrangements (see Section 4.8 below) or through notification of 'cause for concern' cases to safeguarding teams or leads that should have been referred. But these were seen very much as outlying cases and events that would lead to a review of what had gone wrong and discussion with the clinicians involved.

## Referral quality: adequacy of information

A more significant issue was the adequacy of information provided in referrals. As Chart 4.1 showed, there was a very low level of confidence in the acute trust survey about the sufficiency of information provided in referrals: only 14% of trust survey participants agreed strongly that ED staff always refer with sufficient information in cases involving actual or suspected child maltreatment, and 57% agreed slightly. This was generally seen as an area for development in the case studies too, even in areas where the local authority and trust work together most closely, although in most areas it was felt that progress was being made.

The main problems were:

- lack of clarity about the nature of concerns. Both local authorities and trusts in the case studies described cases where the information given suggested low

or no risk – a pregnant woman who had previously been in care, a pregnant 16-year old getting good support from her boyfriend and parents, an ED attendance by a child in a family known to social care but with nothing suggestive of child maltreatment. In other cases what was said in the referral suggested there may be grounds for more concern but the information was too limited or lacked the specificity needed

- use of medical jargon without explanation, not spelling out the implications of what was reported such as a diagnosis or non-compliance with treatment, or lack of analysis of the presenting scenario
- clinicians saying less in the written referral than they had been willing to say verbally
- not giving a rounded picture including positive as well as negative evidence
- in some areas the quality of information was felt to be particularly poor in referrals made over the weekend or at night – perhaps reflecting the lack of involvement of trust safeguarding staff.

Safeguarding teams and social work informants in the case studies described spending considerable time going back to the referrer for more information. Safeguarding teams were seen to play a very important role here, being proactive in spotting inadequate referrals, rapidly following up with the clinician, auditing quality regularly and being very responsive where the local authority flagged inadequate information. There was felt to be particular value in clinicians hearing from someone within their own profession that what they had provided was inadequate. Local authorities said that trust staff were generally responsive when the problems were highlighted but occasionally not, and the trusts described continuing training and feedback to improve information giving.

## Referral quality: thresholds

As noted earlier, the acute trust survey showed that just under two-thirds (64%) of survey participants agreed strongly that they are confident staff know which cases to refer among those in the ED involving actual or suspected child maltreatment, and 34% agreed slightly.

In some case study areas, both with in-hospital teams and with community-based teams, there was felt to be a very good understanding of the threshold a referral needed to reach to be accepted and acted on – local authorities reported it as being very rare that a referral was made that they thought should not have been, and one said a recent audit had identified absolutely no such cases. In other areas referrals below the threshold were not quite as rare but it was seen as inevitable there would be some variability between staff, and local authorities were happy with the situation and would prefer to have the case flagged than not. Aligning views about what should be referred was supported by informal discussion with either safeguarding or the social work team as part of the decision to refer; standing meetings to discuss referrals and joint working practice; the local authority providing clear information about its thresholds, and continued training of trust staff.

*'They have a priority matrix which we have copies of .... We tend to find if we have got concerns and we end up referring they get why we're referring, there's a fair amount of professional respect .... It comes from having good working relationships and them being able ring us up ... we have a mechanism of communication.'*

Acute Trust, community-based social work service.

*'There's always one or two individual cases ... but generally overall the referrals we get now are the ones we should be getting. A lot of it's been that day-to-day frontline working together and behind it there's a lot of work been done through the LSCB, through the partnership groups, through some of the practice groups, through joint training. We have practice meetings regularly of health visitors and social workers together so they learn and work together. We've built up relationships and systems now.'*

Local authority, community-based social work service.

Occasionally either the local authority informant or the trust informant in a case study described more profound difficulties, with a high volume of referrals that the local authority felt should not have been made, or concern on the part of the trust that the local authority threshold for action is set too high. This was felt to be underpinned by, and to perpetuate, poor working relationships and a lack of mutual respect for the work of each agency. These case study areas were also characterised by less extensive processes to support joint working and less informal discussion of cases with social care pre-referral. In one area the social work representative felt health professionals quite profoundly misunderstand the need to work in partnership with the family and the threshold the local authority has to reach in court proceedings, and had unrealistic expectations about what social work interventions would involve.

Over-referring was felt to come from trust staff being anxious and unconfident about safeguarding cases and not being willing to play their part in looking at alternative support options. In one area it was thought that midwives occasionally used child protection systems to try to get underlying social issues, such as housing, resolved for pregnant women. But over-referring was felt to be a dangerous approach: if the referral is not accepted the hospital has lost an opportunity to play its part fully in supporting the family, and the family has been drawn into an invasive and frightening process.

*'I've seen cases where the wrong or no service has been offered to a family because the only response was [to refer to] social services which was the wrong one, and information isn't being shared at the right level to think about what services in the community are needed .... It's a major thing to refer someone into a statutory process and I don't think it's right that we were involving social services [unnecessarily], I don't think that's fair on families.'*

Acute trust, hospital-based social work team.

Overall, having a shared perception of the level of harm needed for social care to be able to act on a referral was seen as supported by informal discussion pre-referral with

either trust safeguarding staff or the local authority or both, and by training, audit, day-to-day work, feedback on referrals from the local authority (see next section), standing meetings and forums for discussing and reviewing joint work, and proactive feedback and supervision within the trust.

## Feedback from social care on referrals

As Chart 4.1 shows, the acute trust survey highlighted social care giving feedback on referrals as a major problem area: only 5% of survey participants agreed strongly and 23% slightly that children's social care always give feedback about next steps following a referral by ED of a case involving actual or suspected child maltreatment.

In the case study areas, too, this was recognised as an area where improvement is clearly needed. Occasionally both the trust and the local authority agreed that feedback was routinely given, although only by hospital-based teams and not by community-based social workers. If cases were urgent or the child admitted, hospital and social work teams would be co-working with a lot of liaison and joint decision-making, so that feedback on the referral was part of this work rather than a discrete activity.

More often both local authorities and trusts acknowledged that feedback was not routine, with the trust usually reporting feedback as less common than the local authority did. At the extreme end trust participants said that feedback was rarely or never given, or only where they had chased for it. Some trust safeguarding teams said they consistently followed up if they did not receive feedback but more often this was done only in urgent cases or might be done by another clinician next time the child or mother attended. As we discuss in Section 4.9, the way referrals are recorded by trusts may make it difficult for them to follow up if the referral is noted in patient records but not centrally logged. Local authority participants felt trusts should follow up more consistently and that this was an important part of joint working.

*'They [the trust] would rightly say they don't get the feedback .... We're aware it's something we need to get better at .... Every referral that we receive, the referrer should be very clear what we've done with that information .... But that referrer also has a responsibility for following up to check we've received it, but I don't think that happens. Basically the referral is sent in a fax to us and that's it. It's almost as if they feel that's it for their responsibility in terms of safeguarding those children.'*

Local authority, community-based social work service.

Despite this variation in reporting of the frequency of follow up, the importance of giving and receiving feedback was universally recognised and was not a point of contention. It was seen as a crucial part of a joint working relationship, a mark of the shared responsibility for safeguarding. It was seen to provide reassurance that the referral had been received and was being acted on, and an opportunity to scrutinise the action taken and escalate the case if there are concerns. The educative role of feedback was also clear – knowing whether a referral was accepted was seen as important in understanding thresholds, improving and shaping practice. Knowing the response was also seen as crucial for future work with the child or family and as part of managing the

anxiety that child maltreatment cases inevitably raise, particularly for staff with less experience of them.

*'First of all [feedback] is important because you need to know what the outcome of your referral was because it may have implications for your clinical management. Secondly I think it's important because it helps you to know what systems are available outside the hospital, it's sort of educational in a way .... And I think people want to know – because it's your case. But the most important thing is the fact that if you've made a referral it's because you felt that was necessary from a clinical point of view [and] a safeguarding point of view, so it may well have implications for your ongoing management.'*

Acute trust, community-based social work service.

The reasons why feedback was not routinely given were also consistently understood: lack of capacity in social work departments, and the difficulty of making contact with clinicians who work shifts. This led to local arrangements in some case study areas to give feedback to a central point in the trust, usually the Named Nurse or other contact in the safeguarding team, who then passed it on, although they faced the same challenges in making contact with staff working irregular hours as local authority staff did. Not having a secure email connection with the trust was a further barrier, and one area had recently set up a semi-automated email system where an email template was generated, pre-populated with the referrer's and child's details, making it easier for a social worker to enter text describing the decision.

Where giving feedback had improved, this generally reflected audits and inspections, the fact that it was given a concerted push by a Director of Children's Services, or the effect of continual nudging and monitoring by a team manager - *'water on a stone'*.

## Back-up systems to ensure referrals are not missed

Some trusts in the case studies described systems for identifying cases, which should have been notified to the safeguarding team or where a referral to social care should have been made. However not all trusts had such arrangements at all, or in both maternity and EDs. The systems described were:

- An arrangement where all cases logged as raising concerns – for example recorded in a Cause for Concern log on the ward, referred to a specialist midwife or highlighted to the safeguarding team using a Cause for Concern or information-sharing form – were reviewed at a standing meeting. This was usually weekly but occasionally fortnightly or monthly. It sometimes took the form of a psychosocial meeting including social workers, and in other trusts was a safeguarding or maternity team meeting. This arrangement would identify cases where a referral should have been made, although of course it would not identify cases where a concern had not been identified or raised at all

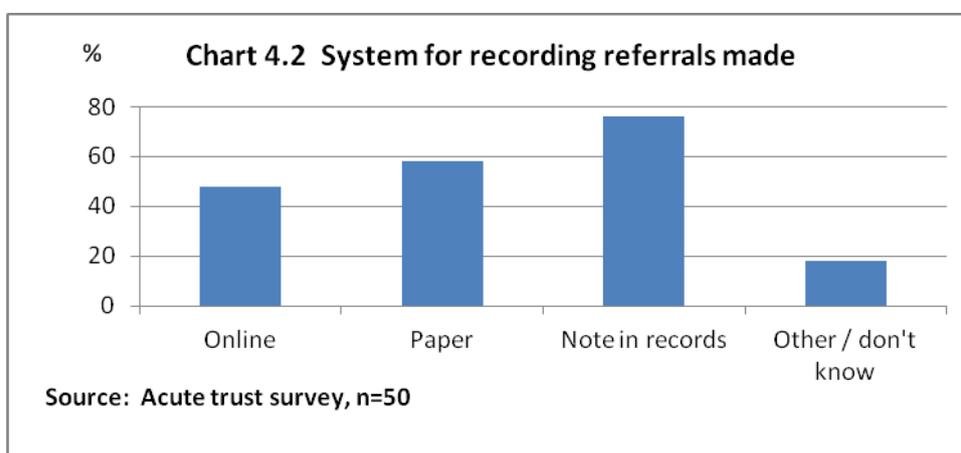
- An arrangement where a Paediatric Liaison Health Visitor, or ED Liaison Officer, reviewed every child record in the ED to check no cases had been missed. It was viewed, among those who used it, as a really important part of their safeguarding process.

*'I think it is really useful because there are certain things a liaison health visitor will pick up that the A&E staff haven't picked up, and that's quite a frequent occurrence. I think it's a really valuable role and it needs to continue.'*

Acute trust, hospital-based social work service.

#### 4.9 Flagging and collating information about referrals

The acute trust survey showed that all trusts had a system for recording the cases referred to social care because of concerns about possible child maltreatment – none kept no record or relied on individual staff to keep a list. Half (48%) reported an online recording system, 58% a paper-based recording system and 76% said a note was made in individual patient records. However, only 39% of those reporting an online system said it operated across the whole trust (the remainder saying it was in the ED only (26%) or in ED plus at least one other department but not the whole trust (35%). Slightly more, 52%, of those reporting a paper-based system said it operated across the whole trust, with 19% saying it operated just in ED, and 35% that it operated in ED plus at least one other department.



The case study trusts described different arrangements for informing safeguarding teams about referrals made – although often they would be involved in the case anyway, having given advice and support around the referral. In some trusts the safeguarding team, or the Named Nurse, was copied in on all referrals. They either reviewed and quality checked them and got any additional information needed, or logged but did not monitor them. In other trusts there was no arrangement for the safeguarding team to be notified and no central log of referrals was kept, although this was acknowledged as an area where a system was needed. Similarly, five of the 50 trust survey participants answering the question (10%) reported referrals being logged

with a note in patient records only, which would suggest there is no central log or list from which referrals can be followed up.

Finally there were different arrangements in the case study areas for flagging referrals to social care, and also notifications to safeguarding, in patient records. They were either scanned into electronic records or included in paper records, with electronic flags and coloured paper used to draw attention to them and references to them in the main patient record. The lack of a single set of records across the trust was a cause of great frustration, and had led to instances where safeguarding information known to one part of the trust had been missed in another clinical area, or not transferred between the mother and a newborn baby's records. One trust had been trying to introduce a single chronology into trust records but was meeting very considerable challenges to doing so.

## Working together on admissions and discharge

The case study trust participants said the trust was generally reluctant to admit a child if there was no medical need because it was not an appropriate way of dealing with child protection issues, but that their safeguarding duty was overriding so they would admit the child if this was necessary for their safety or for investigation. Several said, based on what they knew about other hospitals or had heard from staff, that they had a lower threshold for admitting for safeguarding rather than clinical reasons than other hospitals and that it was rare that a child would not be admitted if there were child protection concerns. Children might be admitted where there was no medical need if the local authority was unable to arrange foster care immediately, particularly overnight or over the weekend. Local authorities were aware this caused difficulties, and trusts similarly challenged local authorities to ensure it did not become common practice. But flexibility and collaboration here was seen as a mark of good partnership working.

In the acute trust survey, 61% of participants said that hospital staff always involve social care in discharge decisions where there is concern about possible child maltreatment, and 34% that they often do. The case studies also showed a degree of fluidity in discharge arrangements. Discharge planning was said to routinely involve social workers where there were safeguarding concerns, both in community- and hospital-based arrangements. There was some variation in how often discussions took place over the telephone rather than face to face: some trusts insisted on a meeting; others used the telephone if there had been a lot of discussion and joint work; others described discussions often happening by phone. Discharge planning was sometimes done at strategy meetings, although again these sometimes took place by telephone.

*'It was a Laming recommendation that no child about whom there are safeguarding concerns should go home without a clear discharge plan .... That's an incident if it does happen.'*

Acute trust, hospital liaison team.

*'If there was actual or suspected abuse or neglect they would have to be admitted, we admit them all. We always have a strategy meeting. If it's section 17 level we would have a pre-discharge*

*planning meeting or a professionals' meeting .... We'd make sure there's a safe plan in place and that everyone has buy-in – the health visitor, GP, social worker, whoever. And if we can't get that safe plan in place we just keep negotiating with our colleagues until we have it even if it means keeping the child in longer.'*

Acute trust, hospital-based social work team.

Case study trust participants described discharge planning also involving other agencies, particularly community health services.

The decision to discharge had to be signed off by a consultant paediatrician in all the case study trusts, and in one trust additionally by the safeguarding team. There seemed to be some shades of difference between trusts in how centrally social care were involved in the decision. In one trust the procedure was very clearly that active consent from social care was needed; in others it was a question of discussion and involvement in the decision. The line taken by local authorities was generally that they needed to be, and were, involved in the discussion but that they needed to be limited to some extent in their responsibility for the decision depending on how involved they had been in the case. One local authority described having been asked to sign off discharges even where the referral had not been accepted, which they had resisted, and another said that they only got involved in discharge decisions if they had done an assessment.

In neonatal cases where concerns had been flagged during the pregnancy, both local authorities and trusts in the case studies said that there would always be extensive joint work and a joint plan, and that the actual discharge decision was sometimes thus a question of notification, or final confirmation by telephone, rather than a formal meeting. Again there were clear protocols about the trust staff who could sign off discharge and about who needed to be notified.

The net result of these arrangements was that all the case study sites felt confident and secure in this area of joint work, viewed it as being of central importance, and said there had been no cases where appropriate joint work had not taken place or that these were extremely rare and taken very seriously. For example there had been occasions where new or inexperienced doctors had failed to follow the agreed arrangements and a child had had to be recalled, or where a planned discharge data for a baby was brought forward without consultation.

## Building and supporting partnership work

Having looked at specific aspects of joint work, we now turn to a wider review of how trusts and local authorities build and support joint enterprise in child protection. There was some variation between the case study sites in how far participants felt there was a sense of joint enterprise between the local authority and trust in cases involving possible child maltreatment and how much interaction there was. Some participants described their work as very integrated, even no longer feeling like two different organisations, while others described less close relationships.

*'It's about involvement in processes within the hospital so they aren't being done separately .... We're not two different organisations. I like it when doctors say "you're part of the hospital" .... Obviously we very much are part of the local authority and that's very important, but we're seen very much as integral to the hospital and that's how it should be .... It's about being on site but also having systems which actually cross over, which aren't being done separately.'*

Local authority, hospital-based social work team.

In this section we look first at opportunities for discussion and joint work in meetings and other settings, and then at other aspects of building and sustaining relationships and joint work.

### Meetings to support joint working

The case study sites described a range of operational and strategic meetings at which local authority and trust staff came together.

First were psychosocial meetings: hospital-based meetings attended by safeguarding, clinical and social work staff to look at cases where there were underlying social concerns – usually a review of all or a sub-set of cases raised as a cause for concern or referred to social care. They generally took place weekly and either on a number of wards or just in the ED or maternity service. There was some variation between trusts in how multi-disciplinary the meetings were, with some involving a wider range of trust-based clinicians than others. They were used to:

- share information between professionals and agencies and assess the level of concern: joining up the knowledge held by different individuals or agencies which might identify a pattern or concern beyond the trigger incident, for example from health and social care, from acute and community staff, from different attendances, about siblings or parents, and *'map[ping] in a more coherent way the episodic things that happen'*. This new information could lead to a review of the concern level, and sometimes triggered a referral where a case had not previously been thought to meet the threshold
- agree next steps and responsibilities

- give feedback on activity since the referral was made
- review the quality of referrals and quality assure, adding more information if required
- discuss wider issues around working together: for example the quality of referrals, any difficulties in accessing information, training needs, etc.

In the trusts which held these meetings they were seen as extremely helpful, a fast and efficient way of managing information sharing and case work and very important in building a sense of joint agency. They were thought to work best where safeguarding was a central focus of the meeting and where the attendance of the social worker was valued and purposeful, and less well where the purpose was primarily clinical overview.

Social workers were only involved in these meetings in case study areas with hospital-based social work teams (including smaller liaison teams), and they happened in all but one of these case study areas. Elsewhere meetings to review cases where wider social concerns had been noted were held but only with hospital staff. Sometimes here, either the trust or the local authority felt that there would be value in expanding membership to a representative from the social work team. But in other areas it was felt that existing mechanisms – informal contact, joint casework, ad hoc meetings on individual cases and other meetings focusing on practice and process (see below) – were sufficient. There was some concern in areas not using these meetings that the discussion at such meetings might be too informal, without sufficient clarity about or documentation of decision-making, and might bypass established systems and procedures. This was not, though, a concern in the areas which held psychosocial meetings, where they were seen as a central part of multiagency working.

**Call for Practice example: Weekly psychosocial meetings. Submitted by: Barking, Havering & Redbridge Hospitals**

A weekly meeting is held with social workers from each of the three local authorities with which the trust works; a representative from Refuge also attends. The meeting is used to discuss all referrals and to review quality and give feedback to referrers and their managers. It enables the agencies to discuss processes that are working or that need to be improved. The trust reports that it supports the identification of children in need and improves communication, information sharing and interagency working.

**Call for Practice example: Weekly Emergency Department safeguarding meetings. Submitted by: Wandsworth Children's Specialist Services based at St George's Hospital, South West London**

The meeting involves the A&E Paediatric Senior Staff Nurse / Sister with Safeguarding responsibility, Social Worker, Liaison Health Visitor, Paediatric Safeguarding Nurse and Psychiatric Liaison. All logged safeguarding referrals to local authorities in the previous week are discussed, outcomes checked and further action agreed. Cases logged as raising safeguarding concerns where a referral was not made are also discussed. Wandsworth report that the meetings have led to more systematic recording of concerns, recording of agreed action plans, improving referral quality, and better following up on safeguarding concerns.

The second set of meetings described in the case studies were meetings with a combined focus on specific cases and on wider review of processes, problems and other issues. They also involved police, particularly in areas with a MASH or similar multi-agency front door, and sometimes also other agencies on an ad hoc basis. Their purpose was to review the quality of referrals and support improvement, to identify lessons or practice development needs highlighted by recent referrals or cases, to resolve problems or unblock processes, to share good practice and to inform joint working processes. They took different forms:

- a weekly moderating panel where a random set of referrals, plus other cases identified as having been problematic, were reviewed in depth, with each agency making its documentation available online
- a regular complex care planning meeting where a multi-disciplinary panel reviews care plans, ensures consistency and trouble shoots problems
- a fortnightly case review meeting to review referred cases which had been in some way problematic
- monthly or quarterly liaison meetings to look at issues raised by recent cases.

Thirdly, some areas also ran different forms of practice network meetings involving larger groups of trust and local authority frontline practitioners in collaborative learning opportunities and reviews of areas of work.

The fourth set of meetings described in the case studies were safeguarding strategy meetings, focusing on the development and implementation of policies, protocols, training, governance, and learning from Serious Case Reviews. These generally met quarterly and again took different forms. In some areas they were the trust safeguarding committee meeting of which a senior local authority member was a member (although there were also areas where the local authority was not represented on the trust's safeguarding committee). In one area the committee included the three local authorities the trust worked with, and this was seen as very helpful for developing consistency and for '*myth-busting*'. In other areas they were other multi-agency safeguarding strategy meetings, sometimes including police.

Finally, there were also other wider local multi-agency groups where joint working on child protection was part of the focus. Key here was the Local Safeguarding Children Board (LSCB). LSCBs were seen as a very important lever for all aspects of multi-agency working, and which several case study participants emphasised were extremely effective in their area – invested with real power by agencies, and with senior staff with decision-making power. Their role in setting the vision, developing policies, leading multi-agency training, scrutiny and performance monitoring, with sub-committees and task and finish groups for more detailed work, was seen as critical.

Other strategic local multi-agency meetings mentioned in the case studies were the Children's Trust in its various forms, Multi-Agency Risk Assessment Conferences and Multi-Agency Public Protection Agreements, and strategic groups leading community based work such as a Sure Start Reference Group and the Family Nurse Partnership Steering Group.

The extent to which case study areas had meetings at each of these five levels varied. There were examples of areas with meetings happening at each level, although they were rare. In other areas there was one or more operational-level meeting and meetings at the LSCB level, but otherwise no identifiable place where strategic level issues could be resolved between the trust and the local authority, or no standing meetings to review cases and operational practice. There was no inclination to have meetings without a clear value, and some of these areas felt they did not need more. But it was striking that the case study areas where both local authority and trust spoke more positively about the quality of joint working did have more meetings, and their importance was strongly emphasised.

*'We've worked quite hard to have enough places to talk about problems.'*

Local authority, community-based social work service.

*'We have regular meetings, regular contact, I suppose we work with the idea of no surprises .... We've got some really good networks where we just get together and resolve problems.'*

Acute trust, community-based social work service.

## Building relationships and joint enterprise

A range of further factors were identified in the case studies as marking and underpinning a sense of joint enterprise:

*Strategic leadership of and commitment to safeguarding children and to multi-agency partnership. Some case study participants talked about there being a very strong local vision for children's wellbeing across the trust and local authority. The local authority and trust treated each other as equal partners with shared responsibilities. The influence of trust executive leads for safeguarding was particularly emphasised as important here, demonstrated by regular meetings with the safeguarding lead, regular access for the safeguarding lead to the trust Board, and an approach which welcomed challenge.*

*Some leads were said to show their commitment through a very hands-on approach – being seen on wards, spending a day with safeguarding staff, putting the Board forward first for safeguarding training. In one area the safeguarding team had recently been moved from the women and children's health division to the corporate division, and this was seen as an indication of the strategic emphasis given to safeguarding. Having the right infrastructure and systems in place to ensure the vision and strategy influenced the whole organisation was seen as important, with an emphasis on processes that made a real contribution to high quality work rather than a focus on monitoring compliance.*

*'It's like any sort of organisational response, isn't it – it has to be right through the organisation. So [the trust has] really good attendance at LSCB, really strong commitment to the working groups .... They allow the staff the time to get involved in joint working on things at a strategic level or at a simple tools level .... [The approach of the trust] right from the top down is safeguarding's important to us, we make that clear throughout the trust, we make it clear to all staff that's our expectation .... There's a kind of mutual respect that's underpinned by all those policies and procedures but, you know, there's a clear line of direction from the top down throughout the organisation that it's an important issue.'*

Local authority, community-based social work service.

*'Having a shared vision [has helped to develop joint work] .... And I think in [this area] we have really got strategic leads who absolutely have a will to try to make things work, to get better .... The vision we have for better outcomes for children and trying to put the building blocks in place in all our services to make those outcomes better, the shared data that we have, the willingness to share information, I think is really powerful.'*

Acute trust, hospital-based social work team.

In most areas, case study participants described a strong sense of leadership. But it was occasionally less emphatic, with local authority and trust participants concerned about over-reliance on safeguarding leads and not having a clear sense of safeguarding being a Board-level priority. Finally a key message many trust informants felt Boards needed to hear was that safeguarding leads need time for their role to be real.

- An organisational culture of learning and openness to challenge. Many case study participants emphasised the importance of honesty and openness in dealings between trusts and local authorities, accepting challenge from each other as positive and constructive, being willing to open up their decision-making and systems to scrutiny, looking at problems without blame, a reflective approach, not being defensive, and being able to talk very directly and transparently. They talked about the starting point for resolving problems always being joint processes, rather than a discussion about how one agency or the other needs to change.

*'It's an open and honest and working together type attitude. Lots of areas say they're working together .... We truly are working together. We cover three local authorities and it's not the same in the other two .... In part it's the people – they need and want to actually protect children .... The Director of Children's Services seems very open. There is challenge from the Safeguarding Children Board, it's not all lovey-dovey and cosy .... I have a*

*fantastic Chief Executive and a fantastic Executive Director, I've not hit anything where they've said 'we can't do it' and I've set them some challenges.'*

Acute trust, community-based social work service.

- Having established communication pathways and strong working relationships between lead staff in the local authority and the trust was critical to this. Listening, responding and being available were important ways of demonstrating openness to challenge. Escalation processes were also seen as an important part of the challenge process, where either agency could escalate a case for consideration by more senior managers if they did not support the decision or action. In practice it was rarely used, or took the form of immediate conversations rather than a formal process, but it was important to have it in place.
- Mutual professional respect. The starting point here was one of different organisational expertise, roles, boundaries, processes, working environments and pressures, which were understood and respected by each agency. This was felt to underpin trust and confidence in each other's work – for example, exemplified by the local authority taking the trust's referrals seriously, the acute trust trusting the local authority's response, and senior clinicians treating social work staff as equals. It created a strong starting point for working together to resolve problems or develop practice.
- Familiarity and personal relationships. It was said again and again that it is much easier to work together when you know the people you are dealing with – particularly when the work is anxiety-provoking and stressful. In-hospital teams were seen to have a real advantage here because of the many more opportunities they created for face to face working, and trust staff frequently commented on how much easier it was to work with hospital-based social workers than those in community teams. But strong personal connections had also been developed in some community-based arrangements. Having key personal contacts was also important for getting wider access within the other agency, with both trusts and local authorities being large and confusing structures where it is easy to lose time trying to find the right person.

*'It's about well-established formal structures, but part of good inter-agency communication work is the informal networks that teams build up as well over time and part of it's the understanding of people's roles and responsibilities – that sort of networking capacity to bypass differences of view and engage constructively, so that's why building relationships and having established relationships is fundamental.'*

Acute trust, hospital-based social work service.

- Individual people and personalities. There were several examples where a new member of staff, particularly a Named Nurse, was said to have moved forward the organisational culture and the quality of joint working very considerably – and also some examples where the change in staffing had been problematic.

*'The role that [the trust Named Nurse] has, there's an equivalent role at the other hospital but I don't think there's as much capacity there, I don't think she works as many hours .... [She's] very passionate about what she does and often that makes a difference, doesn't it, if you've got passionate people leading a service then that kind of brings it on. Her approach is very much about not being led by processes but by the need [of the child] and ensuring concerns are identified and picked up.'*

Local authority, community-based social work service.

- Investment of time and effort. A recurrent message was that building relationships and developing a sense of joint endeavour takes time – *'you have to work at it'*.

*'One of the key things we probably do bring to the game is quite an openness to hearing where we don't get it right and a willingness to look at making it better. I think there is a real responsiveness to hearing those kinds of messages. Our immediate links on safeguarding across the trust have the same approach. Those key relationships and key day-to-day working partnerships are strong and responsive so I think ... investing in those relationships is really, really important.'*

Local authority, hospital-based social work service.

*'It's about forming dialogues. I mean if you haven't got a good relationship you have to sit down in a room and keep meeting people until you have got a dialogue .... It's the basic stuff of getting to know who you need to know, making sure you're attending meetings, making sure you make yourself visible.'*

Local authority, hospital-based team.

- Joint training. Not all case study sites carried out joint training but where it did happen it was seen as a very important part of practice development and an important foundation for joint working. Some trusts (it was not mentioned by local authorities) had gone further and had, or were working on, a system of shadowing or buddying, where early-career staff spent time with a range of staff in both the local authority and the trust to understand safeguarding practice from other perspectives.

- Multi-agency audits, the new Ofsted model for joint inspections, peer reviews, Serious Case Reviews and the SCIE Learning Together review model had also been helpful in highlighting effective areas of joint practice and areas for development, and in supporting a sense of joint enterprise.

Some participants said that being a relatively small geographic area, having lower staff turnover, having fewer hospital sites and working across fewer local authorities also helped.

There were, everywhere to varying degrees, challenges to joint working which put pressure on relationships – extreme busyness, rising demand, financial constraints, cuts in services and resources, organisational restructuring and staff turnover. As we noted earlier, there was particular tension in areas where there were more deep-rooted differences in perception of the threshold for a referral. There was also some tension about provision at the children in need level and below, with concern about both the adequacy of local authority services and the extent to which trusts engage proactively and recognise the contribution they can make.

Trusts were said, by some local authority informants, to be somewhat unfamiliar cultures, even where there was a lot of close working, sometimes surprisingly hierarchical organisations where deference to consultants is still commonplace, where early-career, nursing and social work staff can find it hard to get their voice heard, and where high level technical expertise is not always matched by the focus on organisational processes or some aspects of operational work such as partnership work with the most vulnerable and marginalised groups.

The lack of a shared information system across health and social care was widely commented on as making joint work less easy. Similarly, the difficulties caused by not having a single hospital record system, the need for more coordination of case work within acute care, better coordination and information sharing between acute and community settings, and the need for greater alignment between adult and child safeguarding within trusts were all noted.

## Future challenges to joint work

Finally, two areas of wider policy change were raised by participants as challenges to joint work. First, there was widespread concern about what the introduction of Clinical Commissioning Groups (CCGs) might mean for current safeguarding arrangements in trusts. Concerns here focused on where safeguarding sat in a much more fragmented commissioning landscape, accountability arrangements, access to safeguarding expertise, uncertainty about how CCGs will link with Health and Wellbeing Boards and concern about a loss of emphasis and priority. Even informants who had been impressed by local work to develop CCGs were worried about a loss of emphasis on safeguarding.

*'I think with the significant changes in health commissioning, where do those relationships go and how do we maintain them? If those fragment particularly under the CCGs there are some real*

*risks because you do become very people-dependent if you don't have a strong infrastructure around it. That's the [issue] that most concerns me.'*

Local authority, community-based social work service.

Second, there were different views about the shift in emphasis from central prescription to localism and the removal of procedural requirements, a response to the Munro Review as well as coalition government policy more generally. Although there was positive support for greater emphasis on and space for professional judgement rather than bureaucratic processes, there was concern that this would lead to more inconsistency, and more variation in adequacy and quality, between local authorities' practices and thresholds for referrals. The revised version of Working Together, out for consultation during the fieldwork period, was also widely seen as problematic, again likely to lead to a multiplicity of arrangements with variation in quality, too loose on the importance of multi-agency working and the specific responsibilities of different agencies, and with significant gaps in coverage.

## Discussion

The study highlights diversity between areas in some key aspects of interagency working in child protection, particularly whether and how clinicians have access to information about social work involvement in cases, whether clinicians make full use of relevant clinical expertise, the use of structured approaches to aid risk identification alongside clinical assessment, the amount of input from social care in deciding whether or not to refer a case, approaches to information gathering and information sharing, and the quality and appropriateness of referrals. Given that the case study sites were purposively selected based on evidence of more effective joint working, there is likely to be much that other sites can learn from their approaches.

A strong message from the research is that building and sustaining a partnership approach to child protection requires investment. It requires a shared vision, systems and structures to articulate the vision, clear pathways and protocols, but it also needs people who have time to work together. The hospital-based social work model has many very compelling advantages and was seen as the bedrock of effective partnership working in the case study sites that used it. It is not the only viable model – community-based social work can also be the basis for what was seen as highly effective joint work. But community-based team approaches only underpinned effective interagency working where there was the same investment in time and people – social workers able to come to the hospital at short notice, available for informal advice and discussion, able to respond rapidly in urgent situations; identified lead staff in the trust and the local authority; an expectation and processes for staff to come together to review cases, operational processes and strategy.

The study also highlights questions about how professional expertise, identity, development and networks are sustained in multi-agency settings. Some areas had been prompted to move away from a full hospital-based social work team because risk, decisions and action that were more properly the responsibility of the trust had been delegated to the hospital social work team and the local authority. This was not an issue for the full hospital based teams in the case studies, where this was seen as appropriately joint work. This suggests that the embedded social work model works only where it is part of a commitment to joint enterprise and not a replacement for it. For hospital-based social work teams, this issue of maintaining professional identity and practice also plays out through concerns about how to ensure consistency with community-based cases in whether referrals are made, how they are responded to, and access to partnership work with families and community-based support. Managing hospital-based teams with an eye on this, having systems that provide a check on consistency and ensuring that hospital-based staff maintain good links with the central social work department are important here. Although it is an approach that is only likely to work with sufficient resources, having the team carry some case-management and community-based work (such as pre-birth assessments, as two of the case study teams did) may also be helpful.

The growing number of areas operating multi-agency ‘front door’ systems such as the Multi-Agency Safeguarding Hub also raise questions about how the very strong bi-agency relationships that hospital-based social work supports, play out within wider multi-agency arrangements.

Fundamental to effective joint work is that hospital-based clinicians spot the cases where child maltreatment needs to be considered. Research highlights that child maltreatment is under-recognised and under-referred in health (and other) settings. The case study sites reported little evidence that cases were routinely missed (we were not able to look at compare rates of referral or admission), but they highlighted areas of difficulty particularly around less obvious abuse and neglect. The study raises two particular issues here.

First, the use of structured approaches such as checklists or risk assessment screens on top of clinical assessment, which EDs in particular had introduced. They were generally considered to be effective, provided they were used as an aid to professional judgement and with an absolute focus on *'the child in front of you'*, but there were important concerns that they may distract from what is presented or narrow what is considered in assessing the child.

Second the role of information about cases that are social work active – children with a CPP or families known to social care. On one level it seems intuitively obvious that a clinician should know that a child has already been identified as being at particular risk, and it is easy to understand why Serious Case Reviews frequently call for systems to be put in place or sharpened up if a child known by one agency to be at risk has been missed by another because this information had not been shared. But there is a very clear danger of false confidence if a case is not social work active. Information about social work involvement should be used to step up, but not to step down, the level of concern.

These two approaches are not particularly well evidenced in terms of their effectiveness in increasing appropriate referrals – by which we mean there is inadequate evidence rather than clear evidence of ineffectiveness. A series of systematic reviews funded by the Health Technology Assessment Programme (Woodman et al, 2008; Woodman et al, 2009) looked at the effectiveness of a range of strategies, in addition to standard clinical assessment to identify cases of physical abuse in emergency departments. The study looked for evidence of the effectiveness of: using a checklist; a Community Liaison Nurse (CLN) reviewing all children's attendance records; and using age, injury type, repeat attendance and being social work active as predictors of physical abuse. There was no evidence that any particular strategy was highly predictive, and weak evidence that using a checklist or a CLN improved screening, but the source data was generally limited and of poor quality. The authors conclude: *'We estimated that the best strategy involved the standard clinical assessment screen combined with a CLN.'* (Woodman et al, 2008: 61) and *'Our findings suggest that improving the clinical screening assessment, based on a clinical synthesis of findings in the history and examination, is likely to be more useful than protocols, except where the paediatric expertise of assessors is minimal'* (ibid: 61).

Although there were some references in the case study sites to local investigation of the impact of these approaches on identification, more often the focus appeared to be on checking compliance. There is clearly a need for more research on the impact and effectiveness of additional screening systems. The core message from this study, in the absence of that evidence, is the need for a rounded and in-depth understanding of child maltreatment and of how it may present in clinical settings, and a holistic and open-

mindful assessment of the child. The study also highlights the importance of child maltreatment concerns being identified in adult services, and the need for continued progress here.

This is not the first study to note the constraints that trust record systems place on sharing information, but it was a key source of frustration to trust participants that child protection information cannot always be shared across clinical settings. Information about CPPs or referrals could not always be flagged in the most impactful way or was not visible throughout the trust; child protection information could not easily be shared between mothers' and babies' records. More generally, the critical importance of developing a shared IT system between health and social care was emphasised, and this was seen by some as key to making progress with joint, integrated work.

The issue of feedback by social care to the referrer is also important – to credibility, to attuning understanding of what should and should not be referred, and to informing the referring hospital's continuing work with the child and family. Some local authorities had been able to make substantial improvements by giving more priority to this area of work. In one area more consistent feedback was aided by a social work IT system, which generates a template feedback email, pre-populated with the referrer's contact details and the child's identity from the referral form, for the social worker to add details of actions and decisions. But more generally the low levels of feedback described mean that an important element of partnership working is missing.

The picture that emerges of information gathering and information sharing in cases of concern, particularly those that fall below the level of a social care referral, does not point consistently to joint work on early intervention. In some interviews the focus appeared to be on the decision of whether or not to refer to social care, rather than on engaging early intervention services in support of children and families. This echoes the findings from a programme of studies on child maltreatment (Davies and Ward, 2012) and suggests that we are some way from the Munro Review vision (Munro, 2011) of a coordinated, integrated approach to early help and of an offer of help for children whose needs do not meet the criteria for children's social care services. It reflects the difficulties faced by frontline clinicians in acute services, particularly in fast-moving EDs, in playing a larger role in helping children and families to access community services, as well as the availability of these services. The Munro Review highlights, as this study reflects, that the signs of symptoms of abuse and neglect are often ambiguous and that ready access to social work expertise to discuss concerns is important. Although many of the case study areas describe informal but important interaction to bring social work expertise to bear on cases and decisions, the trust survey shows more ambivalence about the value and use of social work input to the referral decision.

The study also highlights the very heavy demand that child maltreatment places on trust and local authority resources. The fact that the costs associated with this work in trusts cannot be identified and are not taken into account in NHS procedures for payment by results is not helpful here. There are real concerns about how continued cuts in budgets will affect thresholds for social care services and the availability of early help. More generally, the high prevalence of child maltreatment, the fact that most children who are mistreated will not attend hospital, the challenges in identifying and referring all cases of child maltreatment without an unfeasibly high level of false positives, and the high cost

of higher levels of intervention all point to the importance of a public health approach to child maltreatment with an emphasis on early help and prevention.

Finally the study has flagged challenges for the future, particularly the need for more alignment between adult and child safeguarding, the priority of and precise arrangements for safeguarding expertise within CCGs, and how consistent and high quality approaches can be ensured across local areas within a culture of less central prescription.

## Appendix: Research methods

### Local authority and acute trust surveys

Ethical approval for the local authority elements of the research was obtained from the Association of Directors of Children's Services (ADCS) using their online process. We sought advice from the Social Care Research Ethics Council, which advised that since the staff and professionals to be interviewed are employees of NHS Trusts and local authorities and no use of patient or service user data was planned the study did not require ethical approval under GAfREC.

The online local authority and acute trust surveys, and the topic guide for the case study interviews, were developed in consultation with existing literature and research in relevant areas and with very helpful advice and commentary from Advisory Group members. Each was piloted through two telephone interviews with volunteers from the intended survey population and modified.

We initially considered issuing the local authority and acute trust surveys via Chairs of LSCBs, asking them to forward them to the LSCB member representing the local authority and a nominated acute trust. However our consultation with the forum of independent chairs strongly argued against this approach. The online survey of local authorities was therefore sent with a covering email to all Directors of Children's Services, explaining the purpose and content and asking them to forward it to a colleague to participate. The response rate was very low and SCIE made contact by telephone with DCSs and/or with the colleagues to whom it had been passed to encourage participation. From these contacts, the aims of the study appeared to be recognised as important and relevant and no concerns about participating were picked up: it seemed that it was busyness and work pressures that led to such a low completion rate. It is possible we would have secured more responses had we issued the survey to heads of safeguarding although this would have required a telephone screen of local authorities for contact details.

The acute trust survey was issued to trust executives suggesting Named Nurses for Child Protection or Safeguarding as the most appropriate participant. The survey focused only on ED liaison with social care to ensure a single participant could complete the survey. Duplicate completed questionnaires were received from four organisations (in each case two different people completed the survey). Responses were very similar within the pairs and we proceeded by selecting the version that had most completed questions. Fifty-five trusts responded (a response rate of 33%) with the Named Nurse the informant in almost all cases. We were not able to identify an existing list of Named Nurses. A list of Designated Nurses may have been available but when we explored this option we concluded it would be more feasible to go directly to acute trusts. The survey was also promoted through their networks by the Royal Colleges for Nursing, Midwives and Paediatrics and Child Health.

Both surveys invited participants to say if they were happy to be approached about participating in a case study stage and if so to provide contact details. Most indicated they were happy to be approached.

## Case studies

We selected 12 potential case study sites based on indications that they had more effective liaison arrangements. We explored the possibility of selecting them on the basis of either the number of referrals to social care or the number of admissions coded as relevant to child maltreatment or aspects of it. However, our conclusion was that neither category of information would be reliable or could be obtained consistently. Instead our selection of most sites was based on information from the local authority and acute trust surveys. We developed a composite score for acute trusts and selected those with highest scores across the following criteria:

- An increase in referrals
- More positive on attitude statements about ED practice and interagency working
- Regular notification by LA about children with a CPP
- Routine check made on all ED cases as to whether known to social care
- System for flagging CPP cases that operates beyond ED
- System for recording referrals (electronic or paper-based) that operates beyond ED
- Positive comments in open questions about working practices.

We selected LAs with highest composite scores across:

- Increase in referrals
- More positive on attitude statements about ED/maternity practice and interagency working
- Regular notification to trust of children with a CPP
- Provide 24 hour access to check whether child has a CPP or is known to social care
- More regular attendance at hospital meetings and by designated staff
- Positive comments in open questions about working practices.

We also included three sites based on recommendations from the Advisory Group or other information from the field. We modified the selection to ensure inclusion of a range of areas in terms of the nature of the social work service to the trust, region and type of local authority.

Where trusts and local authorities had participated in the survey, we approached the survey informant about participating in a case study; if they had not participated, we approached the local authority head of safeguarding and the trust Medical Director. These approaches were made by email, followed up by telephone, and we suggested the most appropriate participant would be the team manager or head of service (for local authorities) and the Named Nurse and/or Named Midwife (for trusts). We made it clear that we were also approaching the local trust or local authority but wanted to proceed even if their partner agency did not take part. Some organisations responded

almost immediately indicating they were willing to take part; extensive further activity – up to 15 contacts – were required to reach the right willing participant in others.

We carried out twelve case studies with a total of 10 local authorities (12 local authority personnel) and 12 acute trusts (17 acute trust personnel) as set out in the introductory chapter. Local authority participants were mostly team managers, service managers or heads of safeguarding. Trust participants were mostly Named Nurses, with three Named Midwives, two Named Doctors and some staff in other safeguarding roles.

The interviews were carried out by telephone in all but two cases. One paired interview and one single interview with London-based participants were carried out face to face at their request. We asked for an appointment of 60 minutes. Twenty interviews lasted between 50 and 75 minutes, six lasted for over 75 and up to 90 minutes, and two were shorter interviews of 35-50 minutes with secondary informants, which supplemented an interview with the main participant in their organisation. All the interviews were carried out in a single session.

Interviews were digitally recorded and detailed semi-verbatim notes were made through listening back to the recording. The interview data were analysed using Framework, which is a thematic analysis approach in which data are summarised in a series of thematic matrices or tables (Ritchie et al, 2003; Spencer et al, 2013) This study had four thematic matrices (see below). In each, columns represented sub-topics and rows represented individual interviews with interviews in each case study area summarised in consecutive rows. The method facilitates both within-case and within-theme analysis. The four themes (for each matrix) and sub-topics (each represented by a column on the matrix) were:

<p><b>1. Background and staffing:</b></p> <ul style="list-style-type: none"> <li>- summary</li> <li>- informant and organisational context</li> <li>- social work staffing</li> <li>- hospital staffing</li> <li>- pros and cons of staffing</li> <li>- other</li> </ul>	<p><b>2. Identification and referral processes</b></p> <ul style="list-style-type: none"> <li>- approach to identification</li> <li>- confidence about identification</li> <li>- notification and backup systems</li> <li>- access to social work information</li> <li>- health input into cases</li> <li>- referral process</li> </ul>
<p><b>3. Referral quality, feedback and discharge planning</b></p> <ul style="list-style-type: none"> <li>- referral quality</li> <li>- feedback</li> <li>- identification and referral issues</li> <li>- audits</li> <li>- admissions and discharge planning</li> <li>- working across LAs</li> </ul>	<p><b>4. Meetings and joint enterprise</b></p> <ul style="list-style-type: none"> <li>- meetings</li> <li>- joint enterprise and relationships</li> <li>- strategic and cultural issues</li> <li>- other</li> <li>- summary comments</li> </ul>

Verbatim data for quotation was obtained by listening again to specific sections of recorded data and transcribing extracts verbatim.

### Call for Practice

The Call for Practice was issued by SCIE in early 2012, using a modified version of its established online framework. The Call for Practice was publicised via Advisory Group links, and through SCIE's networks. Participants were asked to submit examples of effective practice using the template below.

<b>Name of organisation:</b>	
<b>Contact name:</b>	
<b>Contact email address &amp; telephone number:</b>	
<b>Identification of good practice: Please complete for each example.</b>  <b>What is the practice?</b>	Please provide a description of: <ol style="list-style-type: none"> <li>1. the face-to-face practice and any supporting arrangements or changes, thinking specifically about staffing, information-sharing and access to advice.</li> <li>2. the aims and intended outcomes, including who the stakeholders are.</li> </ol>
<b>What do people think about the practice?</b>	An account of processes and whether stakeholders find them acceptable, including accessibility. Please think about people who: <ol style="list-style-type: none"> <li>1. use services</li> <li>2. work for the acute trust</li> <li>3. work for the local authority</li> </ol>
<b>What happened as a result of the practice?</b>	An account of outcomes and whether stakeholders want them.
<b>How will it be sustained?</b>	What needs to happen to make sure the practice is embedded and can be kept going? (e.g. Do we have the skills? Do we have the right organisational arrangements?)
<b>What are people doing differently as a result of the practice?</b>	What we can learn from the practice and what others can learn.
<b>How do you afford it?</b>	Whether the practice is affordable: any information on costs and savings
<b>Would it work in other places?</b>	What would be your advice to others looking to implement the same practice? Could the learning be transferred to other organisations? Can we spread it?

A total of eight examples were submitted by six organisations (one submitting three). Five of these have been used in the report. The three not used were a practice example which described a similar practice – a psychosocial meeting – to two examples already used; the protocol for a research study which was not yet underway (and had not produced findings by the time the report was written); and the report of a research study which had compared two neighbouring hospitals, one with and one without co-located social workers, and found no significant differences in referral practice over a 28 day period.

## **Limitations of the study methods**

This preliminary study does not make claims to generalisability; rather, it is intended to provide a basis for informed hypothesis formulation. There was a low response rate to surveys, in particular that of local authorities and the selection criteria for case studies mean the survey findings may not be generalisable to all areas. The response rate might have been higher with a different approach (see above). The acute trust survey was relatively short and covered only arrangements in Emergency Departments. The surveys involved one participant and the case studies one or two participants in each organisation, mostly individuals with lead responsibilities for safeguarding and child protection. We cannot assess whether the views and experiences they describe would also be those of other staff within their organisation, and there would be real value in research exploring the experiences, practices and views of samples of frontline practitioners. The inclusion of data on the number of referrals made by and received from acute hospitals, and the number of cases identified as being of concern but not referred, would have strengthened the study and allowed us to look at issues such as whether particular staffing arrangements or identification approaches led to higher rates of referral. However, our early consultation with local authorities and trusts showed that information about the number of referrals made by or received from acute trusts cannot easily be identified consistently by local authorities or trusts.

## **Local authority survey**

### **1. Would you prefer to talk to us before you complete this survey?**

No, please take me to the first question

Yes (you will be asked to provide contact details)

### **This survey will help us to identify sites for follow-up case study work, particularly areas that have useful learning to share.**

Data will be analysed by the research team at the Social Care Institute for Excellence (SCIE) working with Jane Lewis, the SCIE Associate managing the study. Data will be held confidentially and will not be shared with any third party. No local authorities will be identified in reporting the survey findings.

The survey results, along with findings from the other strands of research within this study, will be disseminated as a SCIE report, an 'At a Glance' briefing for Directors of Children's Services and Chairs of LSCBs, through professional journals and at presentations and conferences.

Participation is entirely voluntary, and not connected to any performance management or regulatory process. You are free to withdraw at any time without providing a reason, and there is no obligation to participate in the follow-up case study work.

2. Please indicate that you consent to take part in this survey and accept these terms, by ticking this box:

3. Do you have any children's social work posts based wholly or partly at the acute trust?

- Yes
- No
- Don't know

4. Which of the following services are provided by the acute trust? Please tick one answer for each service.

- Children's accident and emergency services
- Maternity services
- Children's in-patient services
- Children's out-patient services

5. This question is about your arrangements for working with children who present at accident and emergency services at the acute trust. Please tell us whether each area of work is carried out by social work staff in:

- *1 – hospital-based social work posts*
- *2 – posts designated wholly or partly to work with the trust, based in a local authority locality or central office*
- *3 – non-designated posts based in a local authority locality or central office*
- *4 – another arrangement*

If the work is done from more than one location please tell us where the staff who do most of the work are based.

- Provide informal or ad hoc advice to A&E staff on safeguarding issues
- Carry out early intervention or prevention work with families identified by A&E staff
- Provide advice to A&E staff on whether or not to refer a case to children's social care
- Take referrals from A&E staff
- Undertake initial assessments in cases referred by A&E staff
- Undertake section 47 enquiries in cases referred by A&E staff
- Convene child protection conferences in cases referred by A&E staff
- Provide case work to children subject to a child protection plan referred by A&E staff

**6. This question is about your arrangements for working with maternity services at the acute trust. Please tell us whether each areas of work is carried out by social work staff in:**

- **1 – hospital-based social work posts**
- **2 – posts designated wholly or partly to work with the trust, based in a local authority locality or central office**
- **3 – non-designated posts based in a local authority locality or central office**
- **4 – another arrangement**

**If the work is done from more than one location please tell us where the staff who do most of the work are based.**

- Provide informal or ad hoc advice to maternity staff on safeguarding issues
- Carry out early intervention or prevention work with families identified by maternity staff
- Provide advice to maternity staff on whether or not to refer a case to children's social care
- Take referrals from maternity staff
- Undertake initial assessments in cases referred by maternity staff
  
- Undertake section 47 enquiries in cases referred by maternity staff
  
- Convene child protection conferences in cases referred by maternity staff
  
- Provide case work to children subject to a child protection plan referred by maternity staff

**7. Please add any explanation or further information you think is necessary to help us understand your staffing arrangements for work with the acute trust.**

**How many full time equivalent (FTE) children's social work posts are based in the acute trust?**

- Social workers
- Social work assistants
- Social work team managers
- Other social work posts

**8. Which agencies provide funding for these hospital-based children's social work posts?**

- Children's social care
- Acute trust
- PCT
- Don't know
- Other, please specify:

**9. Does the case-load of the hospital-based social work team comprise:**

- Only children who are/have been patients in the hospital trust
- Children who are/have been patients in the hospital trust and also other children in your local authority
- Don't know

**10. Does the hospital-based social work team also provide advice or services in relation to children using the acute trust from outside your local authority area?**

- Yes
- No
- Don't know

**11. What is already working well in the arrangements concerning children outside your area?**

**12. What could be improved in the arrangements concerning children outside your area?**

**13. Have your staffing arrangements for providing a children's social work service to the acute trust changed in the last 24 months?**

- Yes
- No
- Don't know

**14. How have they changed? Please tick all that apply.**

- Did not have an in-hospital social work team 24 months ago and now do
- Had an in-hospital social work team 24 months ago and now do not
- In-hospital social work team now provide more services than they did 24 months ago
- In-hospital social work team now provide fewer services than they did 24 months ago
- In-hospital social work team consists of more posts than it did 24 months ago
- In-hospital social work team consists of fewer posts than it did 24 months ago

- Other, please specify

**15. How likely is it that your current staffing arrangements will change over the next 24 months?**

- Very likely
- Quite likely
- Quite unlikely
- Very unlikely
- Don't know

**16. How do you think they are likely to change?**

- Do not currently have an in-hospital social work team but likely to have one in 24 months' time
- Have an in-hospital social work team but not likely to have on in 24 months' time
- In-hospital social work team is likely to provide more services in 24 months' time than they do now
- In-hospital social work team is likely to provide fewer services in 24 months' time than they do now
- In-hospital social work team is likely to have more posts in 24 months' time than they have now
- In-hospital social work team is likely to have fewer posts in 24 months' time than they have now
- Not applicable
- Other, please specify

**17. Overall, what are the main advantages of your staffing arrangements for work with A&E and maternity staff, in cases of suspected child maltreatment?**

**18. And what, if anything are the main disadvantages?**

**19. Which of these statements best describes the information you have about referrals to the social work service from the acute trust?**

- We can identify and quantify referrals from the acute trust
- We can identify and quantify referrals from all acute trusts or all trusts but not from individual trusts
- We can identify and quantify referrals only from the NHS generally
- Don't know
- Other

**20. Do you know, or can you estimate, the number of referrals you have had from the acute trust in the last 12 months?**

- Yes, the number is \_\_\_\_\_
- No

**21. Has the number of referrals from the acute trust increased or decreased over the last 12 months?**

- Increased
- Decreased
- Stayed about the same
- Don't know

**22. Why do you think this is?**

**23. Are local authority social work staff involved in any of the following meetings, either regularly (all meetings about children in your area) or sometimes (some meetings only)?**

- Pre-birth case planning meetings
- A&E multi-disciplinary or 'psycho-social' meetings
- A&E 'fit for discharge' discussions
- Maternity department multidisciplinary safeguarding meetings
- Maternity 'fit for discharge' discussions
- Hospital safeguarding committee meetings

**24. Which social work staff usually attend pre-birth case planning meetings? Please select all that apply.**

- Member of in-hospital team
- Designated person from locality/central office
- Range of staff from locality/central office team
- Other
- Don't know

**25. Which social work staff usually attend A&E multidisciplinary or psycho-social meetings? Please select all that apply.**

- Member of in-hospital team
- Designated person from locality/central office
- Range of staff from locality/central office team
- Other
- Don't know

**26. Which social work staff usually attend A&E ‘fit for discharge’ meetings?  
Please select all that apply.**

- Member of in-hospital team
- Designated person from locality/central office
- Range of staff from locality/central office team
- Other
- Don’t know

**27. Which social work staff usually attend maternity ‘fit for discharge’ meetings?  
Please select all that apply.**

- Member of in-hospital team
- Designated person from locality/central office
- Range of staff from locality/central office team
- Other
- Don’t know

**28. Which social work staff usually attend hospital Safeguarding Committee meetings? Please select all that apply.**

- Member of in-hospital team
- Designated person from locality/central office
- Range of staff from locality/central office team
- Other
- Don’t know

**29. Does a member of social work staff meet (formally or informally) with acute trust named professionals for safeguarding? (including in meetings that involve other acute trust colleagues)**

**Scale:**

Yes – at least monthly	Yes – but less often than monthly	No
------------------------	-----------------------------------	----

- Named paediatrician:
- Named nurse
- Named midwife

**30. Which social work staff are usually involved in these meetings?**

**Scale:**

Member of in-hospital team	Designated person from locality/central office team	Range of staff from locality/central office team	Other	Don't know
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- Named paediatrician
- Named nurse
- Named midwife

**31. Thinking about staff working in the A&E service of the trust, please say whether you agree or disagree with the following statements about cases involving actual or suspected child maltreatment?**

**Scale:**

Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
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**Statements:**

- I am confident staff in A&E know which cases to refer to children's social care
- I am confident they know how to refer to children's social care
- They always refer cases to us with sufficient information
- They always follow up verbal referrals with a written referral
- We always give feedback about next steps following a referral
- They have sufficient access to social work expertise when they are considering making a referral
- They make full use of social work expertise when they are considering making a referral
- It is helpful if they discuss potential referrals informally with social work staff before making a decision \_\_\_\_\_

**31. Thinking about staff working in maternity department of the trust, please say whether you agree or disagree with the following statements about cases involving actual or suspected child maltreatment?**

**Scale:**

Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
----------------	----------------	----------------------------	-------------------	-------------------	------------

**Statements:**

- I am confident they know which cases to refer to children's social care
- I am confident they know how to refer to children's social care
- They always refer cases to us with sufficient information
- They always follow up verbal referrals with a written referral
- We always give feedback about next steps following a referral
- They have sufficient access to social work expertise when they are considering making a referral
- They make full use of social work expertise when they are considering making a referral
- It is helpful if they discuss potential referrals informally with social work staff before making a decision \_\_\_\_\_

**32. Do you expect staff at the acute trust to complete either a full CAF or a shortened version ('mini-CAF') in relation to cases that involve children who are or have been patients at the trust?**

- Yes – full CAF
- Yes – mini-CAF
- Varies between cases
- Neither
- Don't know

**33. Is a CAF/mini-CAF required as part of the referral process?**

- Yes – full CAF
- Yes – mini-CAF
- Varies between cases
- Don't know

**34. Does the local authority provide a regularly updated list to the acute trust of the names of children who are subject to a Child Protection Plan?**

- Yes
- No
- Don't know

**35. Are trust staff able to contact social care to find out if a child is the subject of a Child Protection Plan?**

- Yes – direct online access
- Yes – 24 hours access by telephone
- Yes – access by telephone during working hours
- No
- Don't know

**36. Are trust staff able to contact social care to find out if a child is known to social care?**

- Yes – direct online access
- Yes – 24 hours access by telephone
- Yes – access by telephone during working hours
- No
- Don't know

**36. How do social workers currently access relevant medical notes of children who are in the acute trust?**

- Direct online access
- Direct access to paper records
- Access provided by request through hospital
- Cannot access records
- Don't know
- Other means of accessing notes, please specify:

**37. Does this provide access only during office hours or also outside office hours?**

- During office hours only
- Also outside office hours
- Don't know

**38. How do medical teams in the acute hospital currently access relevant social work notes for children at the acute trust?**

- Direct online access
- Direct access to paper records

- Access provided by request through hospital
- Cannot access records
- Don't know
- Other means of accessing notes, please specify:

**39. Does this provide access only during office hours or also outside office hours?**

- During office hours only
- Also outside office hours
- Don't know

**40. Overall, thinking about your joint work with the staff in A&E and maternity departments, what, if anything, do you think works particularly well in cases of suspected child maltreatment?**

**41. And what, if anything, do you think could be improved?**

**42. Do you have a service level agreement with the acute trust, or similar document, outlining the nature and extent of social work services provided to the trust?**

- Yes
- No
- Don't know

**43. How far is the acute trust involved in decisions about the nature and extent of social work services?**

- Acute trust is an equal partner with local authority social care in decision-making
- Acute trust is consulted but decisions are made by local authority social care
- Acute trust is not involved or consulted
- Don't know
- Other

**44. Do you have any social work posts based wholly or partly at any other acute trusts?**

- Yes
- No
- Don't know

**45. What is the name of the acute trust you have focused on in this survey?**

**46. What is the name of your local authority?**

**47. What is your job title?**

Email Address:

Telephone Number:

### **Acute Trust Survey**

**1. This survey will help us to identify sites for follow-up case study work, particularly areas that have useful learning to share.**

Data will be analysed by the research team at the Social Care Institute for Excellence (SCIE) working with Jane Lewis, the SCIE Associate managing the study. Data will be held confidentially and will not be shared with any third party. No trusts will be identified in reporting the survey findings.

The survey results, along with findings from the other strands of research within this study, will be disseminated as a SCIE report and as briefings for trust Chief Executives, NHS lead safeguarding professionals, Directors of Children's Services and Chairs of LSCBs. They will also be disseminated through professional journals and at seminars and conferences.

Participation is entirely voluntary, and not connected to any performance management or regulatory process. You are free to withdraw at any time without providing a reason, and there is no obligation to participate in the follow-up case study work.

Please indicate that you consent to take part in this survey and accept these terms, by ticking this box:

**2. Which of these best describes your children's emergency department (ED)?  
Please select one answer.**

- Separate children's ED which is staffed 24 hours a day
- Separate children's ED which is not staffed 24 hours a day

- Designated area for children, staffed 24 hours a day, within the general ED
- Designated area for children, not staffed 24 hours a day, within the general ED
- Don't know
- Other, please specify

**3. When trust staff liaise with the local authority over cases presenting in the ED that raise concerns about possible child maltreatment, which social work staff would they usually contact first? Remember this is about the local authority you work with most often.**

- Social work staff based wholly or partly within the acute trust
- Social work staff who are not based at the trust
- Varies between cases
- Don't know
- Other (please describe)

**4. Are these posts designated specifically to work with the trust?**

- Yes
- No
- Don't know

**5. Which of these systems do you have in the ED for recording the cases that have been referred to children's social care because of concerns about possible child maltreatment? Please tick all that apply.**

- An online recording system
- A paper-based recording system
- A note in individual patient records
- Up to individual staff to keep their own list
- No record kept
- Don't know
- Other, please specify

**6. Where in the trust is this online system in use?**

- Within the ED only
- Within the ED and in at least one other department, but not across the whole trust
- Across the whole trust
- Don't know

**7. Where in the trust is the paper-based system in use?**

- Within the ED only
- Within the ED and in at least one other department, but not across the whole trust
- Across the whole trust

- Don't know

**8. Please add any further information necessary to explain your recording system.**

**9. Overall, has the number of cases presenting in the ED which are referred to children's social care because of concerns about possible child maltreatment increased or decreased over the last 12 months?**

- Increased
- Decreased
- Stayed about the same
- Don't know

**10. Why do you think this is?**

**11. Please say how often each of the following statements are true for staff seeing children in the ED.**

**Scale:**

Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
----------------	----------------	----------------------------	-------------------	-------------------	------------

**Statements:**

- Staff in the ED have sufficient access to relevant clinical expertise from other hospital staff in cases where child maltreatment is considered
- They make full use of relevant clinical expertise from other hospital staff in cases where child maltreatment is considered
- They can get sufficient input from all the necessary clinical staff out of hours in cases where child maltreatment is considered
- They can get sufficient input from children's social care out of hours in cases where child maltreatment is considered
- Hospital staff involve children's social care in discharge decisions where there is concern about possible child maltreatment

**12. Please say whether you agree or disagree with the following statements about cases in the ED involving actual or suspected child maltreatment.**

**Scale:**

Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
----------------	----------------	----------------------------	-------------------	-------------------	------------

**Statements:**

- I am confident staff know which cases to refer to children's social care
- I am confident they know how to refer to children's social care
- They always refer cases with sufficient information
- They always follow up verbal referrals with a written referral
- Children's social care always give feedback about next steps following a referral
- Hospital staff have sufficient access to social work expertise when they are considering making a referral
- They make full use of social work expertise when they are considering making a referral
- It is helpful if they discuss potential referrals informally with social work staff before making a decision

**13. Does the local authority you work with most often provide a regularly updated list to the acute trust of the names of children who are the subject of a child protection plan?**

- Yes
- No
- Don't know

**14. Are trust staff able to contact children's social care to find out if a child is already known to them?**

- Yes, via direct online access
- Yes, via 24-hour telephone access
- Yes, via telephone access during working hours only
- No
- Don't know

**15. When children present in the ED, under what circumstances would staff check whether they are known to social care?**

- Routine check made on all children
- Check made only on some children
- No check made
- Don't know

**16. Please summarise briefly the criteria used:**

**17. Does the ED have a system for 'flagging' cases where the child is the subject of a child protection plan?**

- Yes, via an electronic flagging system
- Yes, via a paper-based flagging system
- No system
- Don't know
- Yes, via another system; please describe

**18. Where in the trust is this system in use?**

- Within the ED only
- Within the ED and one or more other departments but not across the trust
- Across the whole trust
- Don't know

**19. Overall, thinking about staff in the ED and their joint work with children's social care what, if anything, do you think works particularly well in cases of suspected child maltreatment?**

**20. And what, if anything, could be improved?**

**21. What is the name of your trust? (This information will remain confidential and will not be used in reporting the survey findings)**

**22. What is your job title?**

**23. What is the name of the local authority about which you completed this survey? (This information will remain confidential and will not be used in reporting the survey findings)**

**24. May we contact you to discuss whether your trust would be willing to take part in the follow-up case study stage? We would also be happy to speak to senior colleagues as required. If yes, please provide your email address and telephone number**

- No
- Yes

**25. Would you like us to tell you when the study findings are published? If yes, please provide your email address and telephone number**

- No
- Yes

Email Address:

Telephone Number:

Interview guide

The key objectives of the interviews are:

- to get a more detailed description of key aspects of interagency working across LAs and trusts, focusing on cases arising in maternity services and Emergency Depts
- to understand the key points of interaction between trusts and LAs in cases of suspected child maltreatment
- to explore what helps to support effective interagency working
- to gather examples of practices that are viewed locally as effective and useful to share with other areas.

**1. STAFFING ARRANGEMENTS**

- Social work service
  - whether hospital based service: what work does it cover
  - staffing arrangements for:
    - advice about referrals
    - taking referrals
    - acting on referrals
  - what works well, what could be improved
- any changes made or planned: reasons and (anticipated) impacts
  - Hospital service
    - staff (clinical, named or other safeguarding leads, other) involved in:
      - seeing child/parent where concerns about maltreatment
      - deciding whether to make referral inc discussion with social care
      - making referral
      - following up on referrals
    - what works well, what could be improved
  - any changes made or planned: reasons and (anticipated) impacts
  - other key aspects of work of named professionals and their interaction with social care and clinical staff

## 2. IDENTIFYING CASES WHERE CHILD MALTREATMENT NEEDS TO BE CONSIDERED

- Assessment process in ED or maternity: how would cases of concern be identified
  - what issues are clinicians more / less alert to (eg neglect, substance misuse, domestic violence, parental mental health, self-harm)
  - what supports professional practice inc checklists / assessment forms
- how do they work with families in assessing / if issues identified  
Confidence that issues are spotted
  - what gets missed and why
- what's needed to improve identification  
Access to information from social care about CPP / children known
  - what arrangements (proactive notification by LA; checking on specific child where concerns)
  - where in the trust is information held, how made available
  - how well arrangements work
  - how information kept up to date
- what needed to support good practice  
Access to information about prior concerns identified within trust
  - what arrangements
  - where in the trust is information held, how made available
  - how well arrangements work
  - how are they kept up to date
  - what needed to support good practice

## 3. REFERRALS AND FOLLOW-UP

- What works well, what needs to be improved in:
  - deciding whether to make a referral
    - who involved
    - clarity of thresholds
    - value of discussion between trust and social care; among trust colleagues
  - making referral
    - who involved
    - how referral is made
    - timeliness of making referral
    - information gaps: why, what difference does this make, how to improve
  - taking and responding to referral
    - who
    - timeliness of response
  - giving feedback on referral
    - who does it need to be given to
    - what type of feedback needed
    - why is it important
    - why doesn't it happen
- protocols covering these arrangements: impact, value  
Recording/notification and follow-up of referrals
  - systems for recording, notification, follow-up
  - who has access to information and how: implications of this
  - who follows up and how
    - clinical/multiagency meetings and decision-making
    - monitoring, audit
  - protocols
  - what works well, what needs to be improved and how

#### **4. ADMISSIONS AND DISCHARGE**

- Circumstances under which child/parent is admitted if concerns about maltreatment
  - involvement of social care
- Arrangements for discharge
  - social care / multiagency involvement
  - timing of referrals (eg after case conference / strategy discussion)
  - protocols
- What works well, what needs to be improved and how

#### **5. KEY POINTS OF INTERACTION AND RELATIONSHIP BUILDING**

- Importance of and how to support:
  - informal discussion and interaction
  - key meetings: which, who attends / should attend  
eg pre-birth case planning; psychosocial meetings; discharge discussions; safeguarding committee meetings; meetings between social care and named professionals
- other key types of interaction  
How far are there strong interagency relationships
  - what supports this, what's needed
- How far is there a sense joint enterprise and shared practice in safeguarding
  - what facilitates or obstructs this
  - use and value of protocols and documented agreed procedures: which areas, how used
  - what's working well, what improvements are needed

#### **6. OTHER AREAS OF JOINT WORK IN SAFEGUARDING**

- Working across boroughs
  - what issues does this raise
- what's working well, what improvements are needed  
Joint working where trust input needed during course of safeguarding case work (eg child referred for specialist assessment)
  - what works well, any areas of difficulty, how to improve
- Strategic support for joint working
  - where and how are areas of difficulty resolved
  - quality of strategic support
  - any areas of difficulty
- Any other areas of joint work re child maltreatment not discussed

#### **TO CONCLUDE**

- What aspects of local practice are most effective, what could other areas learn
- What isn't working well, what do they need to learn from other areas
- Anticipating future change: what will it mean for interagency working in cases of suspected child maltreatment
- Final messages for
  - colleagues and counterparts
  - Chief Exec, DCS, LSCB
  - professional bodies or other stakeholders
  - government

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## Partnership working in child protection: improving liaison between acute paediatric and child protection services

This study was carried out by the Social Care Institute for Excellence (SCIE) as part of the programme of work of the Policy Research Unit in the Health of Children, Young People and Families (CPRU), funded by the Department of Health. The views expressed are not necessarily those of the Department. The aim was to understand how acute paediatric and local authority statutory child protection services work together in cases of suspected child maltreatment. In particular, the study looks at what is viewed locally as good practice in staffing, identifying cases where child maltreatment should be considered, referring cases to social care and information-sharing, and to explore what supports interface arrangements that professionals deem most effective.

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