Improving practice in safeguarding at the interface between hospital services and children's social care: a mixed-methods case study

Susan White,[1*] David Wastell,[2] Suzanne Smith,[3] Christopher Hall,[4] Emilie Whitaker,[1] Geoff Debelle,[1,5] Russell Mannion[1] and Justin Waring[2]

[1]School of Social Policy, University of Birmingham, Birmingham, UK
[2]Nottingham University Business School, University of Nottingham, Nottingham, UK
[3]Trust Headquarters, North Manchester General Hospital, Pennine Acute Hospitals Trust, Manchester, UK
[4]School of Medicine, Pharmacy and Health, University of Durham, Stockton-on-Tees, UK
[5]Birmingham Children's Hospital, Birmingham, UK

*Corresponding author

Declared competing interests of authors: none

Published February 2015
DOI: 10.3310/hsdr03040

Scientific summary

Safeguarding children between hospital and social care
Health Services and Delivery Research 2015; Vol. 3: No. 4
DOI: 10.3310/hsdr03040

NIHR Journals Library www.journalslibrary.nihr.ac.uk

Scientific summary

Background

Hospitals feature significantly in the lives of many children who come to harm at the hands of their parents or carers, and diagnostic and other errors are not uncommon. These have proved resistant to standard policy responses, and reviews into decision-making in high-profile cases tend to reassert familiar imperatives – particularly that professionals should 'share information' in order to identify and protect children at risk. Despite radical reforms to safeguarding processes and systems over the last 10 years, errors and failures persist in detection and intervention when children at risk present at secondary care. There is a central moral tension between the rights of the many to freedom from scrutiny and intrusive intervention into family life and those of the relatively few who come to serious harm at the hands of their carers, which has made the accurate detection of children at risk a really 'wicked issue' for the human actors involved.

Safeguarding children is socially, emotionally and cognitively complex. Signs and symptoms are often ambiguous. It often falls into the interstices between organisations and governance systems, with a consequent lack of clarity about responsibility compounded by problems in communication and knowledge sharing across space, time, and organisational and professional boundaries. As a high-risk, high-blame activity, safeguarding is also buffeted by media scandals, which create further barriers to co-operation. Errors have proved resistant to standard policy responses, which are typically process oriented. The last decade has seen the rise of the patient safety paradigm in health emphasising social and organisational processes, including the importance of communication, feedback loops, confidential reporting and organisational learning. However, these are rarely modelled in detail to take account of the social and cultural dynamics of child health settings and children's safeguarding.

This study is focused on supporting and evaluating clinician-led service design in an acute trust in the north-west of England, where the relative neglect of safeguarding in patient safety initiatives had prompted senior clinicians, with strong support from the executive board, to rethink their processes and practices. A suite of initiatives and artefacts has been designed, based on the view that only a thorough understanding of human, social and organisational challenges will afford effective solutions. The intended outcome is to create a positive safety culture, characterised by openness, justice and learning, where learning from error is regarded as the norm.

Objectives

This project followed a 'design science' approach aimed at creating a culture of safe practice with children at risk. It addresses the following primary question:

'Can a safeguarding culture be designed within the hospital environment that will provide the conditions for the detection of children at risk of abuse and support protective actions before discharge, including collaboration with external agencies?'

More specifically, the objectives included:

- the development of a sociologically rich understanding of why diagnostic failures and communication breakdowns occur
- the design of a suite of integrated interventions for promoting a positive safety culture, following a user-centred approach
- the evaluation of the effectiveness of this package, including its generalisability across sites.

Methods

The study took place in two sites. The centrepiece of the work, from a design point of view, was a package of technical interventions designed at the primary site, which comprised a number of artefacts aimed at enhancing safeguarding. This suite included senior management walkrounds and an electronic referral form (based on the NHS Patient Safety Paradigm), as well as mechanisms for the sharing of safeguarding narratives through digital stories and 'peer review' case discussions. The original rationale for the second site was to investigate the transferability of the package. In the end this was not possible, largely due to difficulties in adapting information technology (IT) systems, and so the second site was used as a comparator.

The investigation followed a *design science* approach. In contrast to conventional social science, the aim of design science is to develop a corpus of practically oriented knowledge regarding the design, implementation and use of a general class of artefact, technology or service innovation. The design orientation of the research and the novelty of the clinical problem required an emergent and open methodological approach. The proper evaluation of a design intervention relies on a rigorous understanding of the realities of everyday practice. Thus, the study draws on methods associated with interpretive sociology to examine the linguistic and other practices which produce and reproduce 'cultures' in our studied organisations.

The mixed-methods research design has involved the following data collection methods.

Qualitative interviews

Semistructured qualitative interviews were used to understand how safeguarding activity, and interprofessional and interagency working were organised and experienced by key clinicians and managers. A total of 61 interviews were carried out, with 56 different individuals (a small number of staff were interviewed more than once, e.g. the heads of safeguarding at the two research sites). These were supplemented by interviews arising from ethnographic observations, which were recorded in detailed field notes.

Focus groups

Two focus groups with nurses based in different settings took place in the primary site, which explored similarities and differences in staff members' understandings of the safeguarding process.

Observations

To deepen our understanding of the roles and contributions of key individuals, shadowing observations were also undertaken with key individuals. Observations were also undertaken of the sense-making at the receiving end of information sharing in community health settings and children's social care (CSC).

Analysis of case notes, documents, policies and routine data

Various audit, strategy and policy documents were analysed from both the primary and the secondary research sites. These included formal policies and pathways for referral, patient leaflets and guides, and pictures of posters, fact sheets and other information. Routinely collected performance data relating to safeguarding at each site were analysed, including the numbers of referrals to CSC and the quality of information shared. Detailed analysis of decision-making and systemic incidents analysis was undertaken with a sample of four anonymised medical files, selected for their typicality.

Case tracking

In the primary site, a sample of cases that were referred to CSC were tracked. In the second site, referrals are routinely tracked and the research team had access to those data.

Design workshops

Meetings of the whole project team took place approximately every 6 months. These reviewed progress and also functioned as design workshops where innovations were shared and discussed. This created a

© Queen's Printer and Controller of HMSO 2015. This work was produced by White *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

collaborative clinical network, which continues and has proved very fruitful. There is evidence that this kind of peer support has considerable potential for development nationally.

Quantitative data

A range of quantitative metrics were gathered. Examples of such metrics include the number of referrals from the hospital to local CSC organisations. A bespoke staff survey of attitudes to safeguarding in Pennine Acute Hospitals Trust was also carried out.

Results

The data from this study further the understanding of the complexities of sense-making and knowledge sharing in safeguarding contexts. It is vital that these are properly understood if the developments and artefacts at our primary site are to be accurately appraised. The artefacts themselves seemed to be broadly successful, in particular the electronic reporting tool, which was nominated for a patient safety award. Walkrounds have promoted stronger 'board to ward' communication and 'peer review' case discussions have helped to foster a more reflective and collaborative 'learning culture'. The openness to being challenged and to changing opinions and processes are evidenced in the interviews and in the everyday practices observed by the team. However, 'wicked issues' remain, which can be categorised into two main areas: the difficulty of making sense of complex cases, and the intrinsic difficulties of sharing knowledge between different professional groups and across organisational boundaries.

Sense-making in safeguarding cases

In policy terms, safeguarding is 'everyone's business' and vigilance is vital and culturally valued, but the majority of presenting cases in acute settings are not safeguarding matters. So, detecting children at risk is a complicated business. For example, if a child has cerebral palsy and has difficulty swallowing and chewing, it becomes expectable that his/her weight gain may be slow. This exists as an available explanation for poor weight gain and, in absence of dramatic weight loss, clinicians need not necessarily investigate further. Further investigation must, therefore, be triggered by something else, and this is a highly contestable and often practically onerous process relying substantially on moral judgement and techniques of persuasion. Moreover, many candidate-safeguarding cases result from clinical contact with adults rather than children themselves. This may occur in maternity services as a result of concerns about a woman's drug use or her exposure to domestic abuse, or as a result of adults' presenting at the emergency department. Serious physical injury accompanied by an implausible parental explanation is tragic for the child but is organisationally and clinically easy to manage. Far more common are cases in which the significant players in the family and professional network are dispersed through time and space. The propensity to 'look deeper', or to 'seek more information' or 'missing pieces' is not evenly distributed among clinicians. In the majority of cases, 'telling the case' is as important as the hands-on, diagnostic work.

Two contrasting moral positions can support case formulations about risk, which may be described as 'proportion' versus 'precaution'. That is, the clinician may invoke the precautionary principle – better safe than sorry – or they may instead assert the necessity for clinical pragmatism and proportionality. These coexist as potential mandates for a diverse range of possible decisions and disposals in individual cases where the presentation is open to interpretation. It is because these two contrasting positions are always available that practice tends to be relatively resistant to control with protocols and guidelines, even where these are clear and unequivocal.

Knowledge sharing in safeguarding

Further complexities arise from the need to pass unclear, speculative and ambiguous information across service boundaries. Health and social care professionals are committed to promoting the safety and well-being of children and families. They are also committed to interagency working through sharing information and collaborative interventions. Much effort is exerted in establishing structures and protocols to this end; however, a wide range of factors get in the way. There are different professional perspectives,

working practices and organisational structures, and high levels of anxiety and pressure. Information is changed as it crosses organisational boundaries, especially where there is a reliance on information and communication technologies. The 'jigsaw' may be incomplete, and the professional concerned may or may not know that some of the pieces are missing. The construction of a 'full' picture is inevitably contingent upon actions and talk within settings, and may or may not be subject to ongoing revision. CSC services face unprecedented levels of demand, a problem exacerbated by the fact that they are key to other organisations managing their own (institutional) risk. Contact with children or parents in hospital is fleeting, so there is almost always an information 'deficit'. This can potentially trigger referrals to CSC on a precautionary basis. The development of a referring culture from a health perspective can be seen as a big step forward when there have been significant and enduring problems in keeping safeguarding concerns at the forefront of busy clinicians' minds. While these referral practices makes sense within the high-risk context of institutional accountability in health, the systemic effect on CSC is very significant. High demand and a referring culture are likely to generate vigorous gatekeeping behaviours in CSC. CSC 'gatekeep' and their health colleagues try to 'gatecrash' to manage their own risk in a high-blame environment. Both practices are rational but potentially systemically unsafe.

Conclusions

If safeguarding children is to become mainstream patient safety business, board support is vital. In our primary site, there has been a steady integration of learning from serious case reviews and other child protection-related processes with 'patient safety'-related incidents. There has been a growing recognition that the same systemic issues impact on both domains. So, culturally, safeguarding is seen as part of the quality framework of the trust. Using the language of patient safety appears to have been pivotal. Cultures speak themselves. Making use of a familiar vocabulary to redescribe *safeguarding* as a *safety* issue, and therefore as something fundamental to the functions of an acute hospital, has been part of the success.

The experience in the primary site suggests that persistence, resilience and vigilance from the safeguarding leadership and executive teams are crucial. The importance of user-centred design, piloting, incrementalism and a thorough empirical engagement with everyday practices and emerging patterns seem essential.

There remain significant challenges in promoting safe practice. Top-down approaches to risk management can inhibit effective and skilled professional practices. Professionals must negotiate the contingencies of each and every case. The curtailment of the reflexive, dialogical spaces necessary to undertake safeguarding work thus increase the likelihood of error. Face-to-face relationships make safe teams. The assumption that electronic systems facilitate better 'information sharing' merits more critical examination. Poorly designed or precipitously imposed technologies can act as a barrier to human communication and sense-making. Electronic systems work well for particular kinds of knowledge. If knowledge is explicit and expressible, it can be moved around using IT and conveyed in documents, e-mails and databases, as well as through meetings and briefings. However, much of the knowledge in the detection of a child or family at risk is tacit and difficult to codify. It is experiential, active and alive, and expressible through direct interaction. When technological developments disrupt this – for example, the use of a call centre to filter all communication or discouraging staff from talking about cases unless they have received a referral in a particular format or one already entered onto the system – the translation of tacit understandings and 'gut feelings' into explicit and communicable knowledge is rendered extremely problematic.

Funding

Funding for this study was provided by the Health Services and Delivery Research programme of the National Institute for Health Research.

© Queen's Printer and Controller of HMSO 2015. This work was produced by White *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

Health Services and Delivery Research

ISSN 2050-4349 (Print)

ISSN 2050-4357 (Online)

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) (www.publicationethics.org/).

Editorial contact: nihredit@southampton.ac.uk

The full HSDR archive is freely available to view online at www.journalslibrary.nihr.ac.uk/hsdr. Print-on-demand copies can be purchased from the report pages of the NIHR Journals Library website: www.journalslibrary.nihr.ac.uk

Criteria for inclusion in the *Health Services and Delivery Research* journal
Reports are published in *Health Services and Delivery Research* (HS&DR) if (1) they have resulted from work for the HS&DR programme or programmes which preceded the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors.

HS&DR programme

The Health Services and Delivery Research (HS&DR) programme, part of the National Institute for Health Research (NIHR), was established to fund a broad range of research. It combines the strengths and contributions of two previous NIHR research programmes: the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme, which were merged in January 2012.

The HS&DR programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services including costs and outcomes, as well as research on implementation. The programme will enhance the strategic focus on research that matters to the NHS and is keen to support ambitious evaluative research to improve health services.

For more information about the HS&DR programme please visit the website: http://www.nets.nihr.ac.uk/programmes/hsdr

This report

The research reported in this issue of the journal was funded by the HS&DR programme or one of its preceding programmes as project number 10/2002/52. The contractual start date was in April 2012. The final report began editorial review in January 2014 and was accepted for publication in June 2014. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

© Queen's Printer and Controller of HMSO 2015. This work was produced by White *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

Published by the NIHR Journals Library (www.journalslibrary.nihr.ac.uk), produced by Prepress Projects Ltd, Perth, Scotland (www.prepress-projects.co.uk).

Health Services and Delivery Research Editor-in-Chief

Professor Ray Fitzpatrick Professor of Public Health and Primary Care, University of Oxford, UK

NIHR Journals Library Editor-in-Chief

Professor Tom Walley Director, NIHR Evaluation, Trials and Studies and Director of the HTA Programme, UK

NIHR Journals Library Editors

Professor Ken Stein Chair of HTA Editorial Board and Professor of Public Health, University of Exeter Medical School, UK

Professor Andree Le May Chair of NIHR Journals Library Editorial Group (EME, HS&DR, PGfAR, PHR journals)

Dr Martin Ashton-Key Consultant in Public Health Medicine/Consultant Advisor, NETSCC, UK

Professor Matthias Beck Chair in Public Sector Management and Subject Leader (Management Group), Queen's University Management School, Queen's University Belfast, UK

Professor Aileen Clarke Professor of Public Health and Health Services Research, Warwick Medical School, University of Warwick, UK

Dr Tessa Crilly Director, Crystal Blue Consulting Ltd, UK

Dr Peter Davidson Director of NETSCC, HTA, UK

Ms Tara Lamont Scientific Advisor, NETSCC, UK

Professor Elaine McColl Director, Newcastle Clinical Trials Unit, Institute of Health and Society, Newcastle University, UK

Professor William McGuire Professor of Child Health, Hull York Medical School, University of York, UK

Professor Geoffrey Meads Professor of Health Sciences Research, Faculty of Education, University of Winchester, UK

Professor John Powell Consultant Clinical Adviser, National Institute for Health and Care Excellence (NICE), UK

Professor James Raftery Professor of Health Technology Assessment, Wessex Institute, Faculty of Medicine, University of Southampton, UK

Dr Rob Riemsma Reviews Manager, Kleijnen Systematic Reviews Ltd, UK

Professor Helen Roberts Professor of Child Health Research, UCL Institute of Child Health, UK

Professor Helen Snooks Professor of Health Services Research, Institute of Life Science, College of Medicine, Swansea University, UK

Please visit the website for a list of members of the NIHR Journals Library Board:
www.journalslibrary.nihr.ac.uk/about/editors

Editorial contact: nihredit@southampton.ac.uk