Shared Responsibility

Safeguarding arrangements between hospitals and children's social services

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national
children's
bureau

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Contents

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Introduction

The National Children's Bureau has been funded by the Department of Health to investigate the interface between hospital and social services staff with a responsibility for children in need. Interest in this topic arose from the recent Inquiry into the death of Victoria Climbié (Department of Health and Home Office 2003) which stressed the important roles of both agencies in the safeguarding of children. Although the impact of Victoria's death has been enormous, the failures highlighted in multi-agency working are depressingly familiar. Inquiries into other child deaths (Reder et al 1993; Falkov 1996; Brandon et al 1999; Dale et al 2002; Sinclair and Bullock 2002) have consistently referred to poor communication between agencies as a key component in the failure to protect vulnerable children. In many cases the failure of communication has been between hospital staff and social workers. Each Inquiry has led to procedural recommendations designed to improve the mechanisms for joint working but Victoria's death suggested that more needed to be done. Perhaps a key issue is the difference between inter-agency *procedures* and the reality of inter-agency *working* (Murphy 1995, 2004).

This project has attempted to explore this working relationship in more depth by:

- surveying the working arrangements between hospitals and social services departments across England;

- reviewing relevant literature;

- undertaking an in-depth analysis of practice in three hospitals;

- analysing the above data to draw out implications for safeguarding and promoting children's welfare.

This report and practice recommendations are the result. It is hoped they will support hospitals and local authorities in meeting the requirements of the National Service Framework for Children, Young People and Maternity Services and the Children Act 2004. More importantly, the report attempts to highlight the ways in which hospitals and children's social services can improve their working relationships in order to safeguard and promote children's welfare more effectively. The consequences of getting this relationship wrong are starkly illustrated by Victoria's death and the report begins with a reminder of these messages.

The challenge of working together

> *All the evidence indicates that children are safeguarded best where there is clarity and understanding between different agencies about roles and responsibilities, underpinned by good working relationships at all levels* (CSCI 2005 p.33).

Victoria Climbié

Victoria Climbié died aged eight years of multiple injuries inflicted by her carers. In his opening statement to the Inquiry undertaken by Lord Laming, Neil Garnham QC listed no fewer than 12 key occasions when the relevant services had the opportunity to intervene, including two occasions when Victoria had been admitted to hospital.

Victoria's first admission was to Central Middlesex hospital with bruising and bloodshot eyes. Although her childminder and junior staff within the hospital suspected physical abuse, the consultant paediatrician concluded that the marks were caused primarily by scabies and that there were no indications of physical abuse. There was no social work team within the hospital and the referral was dealt with by Brent social services' local child protection team. Once they were advised of the consultant's opinion, they did not proceed with their enquiries and Victoria was allowed to go home. The consultant paediatrician responsible subsequently stated that she had expected social services to continue their enquiries in spite of her medical opinion. This raises important questions over the respective roles and responsibilities of social services and hospital staff, and over who has the authority to 'diagnose' abuse and to determine future action.

Ten days later, Victoria was admitted to North Middlesex hospital with a scald to her face. North Middlesex hospital is located in the London Borough of Enfield which was therefore responsible for employing the hospital social workers and, having made some preliminary enquiries, the hospital social worker referred the case on to Haringey social services (as Victoria lived in the London Borough of Haringey) for investigation without seeing or speaking to Victoria. Although the explanation for the scald appears to have been accepted hospital staff were by then concerned because of old marks on her body consistent with being hit by a belt buckle. They also felt that Victoria was nervous of her 'mother' and unkempt. At a strategy meeting convened by Haringey social services it was decided to undertake child protection enquiries but these were never completed satisfactorily. After a visit to Victoria on the ward by the Haringey social worker and a police officer, it was decided that she could go home.

Failings

Lord Laming concluded that both hospital admissions were missed opportunities to protect Victoria. He cited a catalogue of failures by hospital staff.

> *Inadequate and ambiguous recording of information and actions, deferred actions, assumptions and expectations that things 'would happen' or be done by 'someone' or others 'at a later stage'.*

Lord Laming also commented on the response by social services to the hospital referrals. In relation to Brent, he criticised social workers for allowing a doctor to decide that there were no longer child protection concerns, in spite of the fact that social services has responsibility for investigation and assessment under these circumstances. Poor communication between social workers and the relevant staff within the hospital was also noted, including the failure to have any proper multi-agency discussion or planning.

Haringey social services were said to have a poor working relationship with the North Middlesex hospital and had no social workers based there. In spite of their stated policy of holding strategy meetings within the hospital where children were in-patients, this did not happen and important medical and nursing opinions was missed as a result. Furthermore, the medical investigations required to establish the cause of Victoria's injuries were not carried out, and there was no review process that would have revealed this. Instead, there were a series of unsatisfactory conversations, letters and subsequent misunderstanding between social services and medical/nursing staff. Of particular concern was the decision to discharge Victoria without any proper investigation or plan, and with a lack of clarity about where the authority for such a decision lay.

Finally, Enfield social services were criticised because of the lack of a clear role for the North Middlesex hospital social worker in relation to children from another local authority. Although it had been negotiated that Enfield would undertake some initial work before transferring responsibility to a patient's home authority, Lord Laming commented that there was confusion about where Enfield's responsibility ended and Haringey's began. Further concerns were that the Enfield social worker was managed within the adult division of social services and did not therefore have adequate support and supervision to work with children, and social workers had ceased to attend hospital meetings where concerns about children were discussed. The latter decision seems to have been a symptom of conflict between social work and medical staff, with social workers feeling deskilled and devalued. Overall, Lord Laming questioned the value of the hospital social worker acting as a 'conduit' of information rather than undertaking an Initial Assessment him or herself.

Recommendations

A number of the report's recommendations are relevant to the safeguarding of children in hospital. For directors of social services, this included an explicit responsibility for making sure that child protection concerns are fully investigated and a social work plan put in place before discharge home (recommendation 56). The working arrangements of hospital social workers responsible for children were also the subject of recommendations, including their line management (60) and the development of a single set of social work guidance across authorities served by a hospital (62). The tasks of hospital social workers were also mentioned, with recommendations that they must participate in all hospital meetings concerned with the safeguarding of children (61) and respond promptly

to any referral of suspected deliberate harm to a child including seeing and talking to the child and carers (63).

Similar recommendations were made for NHS Hospital Trusts, including the need for a senior paediatrician's permission before discharging a child for whom there are child protection concerns (70). More robust systems for recording and sharing concerns were recommended, with clarity about who is responsible for taking action (77,80).

Comment

The above recommendations have been accepted and incorporated into revisions of the law, policy and procedures. They are to be welcomed for their intention to introduce more rigour into the response to concerns about children's safety and welfare, and to clarify lines of accountability. They implicitly acknowledge that abuse of children cannot easily be 'diagnosed' and that there will be differences of opinion amongst professionals. Even in cases where the medical facts are clear, there will still be a need for social services to undertake an assessment of the child's family circumstances before a plan can be formulated. In short, child protection work is a multidisciplinary task.

Interestingly, in spite of this recognition, the recommendations are directed at single agencies. They focus on the procedural arrangements rather than the working relationships between hospitals and children's social services. The difficulties described by practitioners in feeling devalued, or not being taken seriously, *may* be eased by new procedures but there are likely to be other factors that influence the ability to work together. If judgements about child protection are essentially negotiated rather than diagnosed, then the key component is effective communication.

The recommendations do not address this, and the question about who is 'in charge' remains unresolved. Both senior paediatricians and social services are given responsibility for deciding when a child can be discharged from hospital. This raises the question about the evidence on which this decision will be based. Child protection work is not a science: it is a question of judgement, from deciding the threshold for referral between agencies to deciding that a child will be safe if discharged home. An additional complication is the role of hospital-based social workers, particularly where children are admitted from another local authority area. The recommendations appear to suggest that these workers should be taking greater responsibility but it is unclear how this could work in practice. It also begs the question about who will fulfil this role in the many hospitals *without* any social work presence.

Are there any lessons from the literature about the challenges facing children's services and hospitals in the effective safeguarding of children?

Messages from the literature

Barriers to effective collaboration

Poor communication

> *Clear and open communication between professionals and agencies is fundamental to the successful management of the issues and challenges we face as we endeavour to protect children.* (Chief Nursing Officer, Christine Beasley 2003)

Communication between professionals is cited repeatedly in the literature as being the key element in effective multi-agency work to safeguard children. Reder and Duncan (2003) note that evidence of communication failures between professionals was found in almost all reviews of serious cases of child abuse.

An essential element of communication is the exchange of relevant and timely information between professionals. Reder and Duncan found a lack of information sharing between professionals – as well as delays and inaccuracies – was recorded in most of the case reviews they examined. Sinclair and Bullock (2002) reviewed 40 Serious Case Review reports and noted that there was inadequate sharing of information in 25. They found several cases of cumulative risks to individual children which were noted by separate agencies but not explored or acted upon. They describe how one boy, for example, suffered severe cruelty even though his attendance at school was poor, his name had previously been on the child protection register, his mother had mental health problems and abused drugs and a violent male with a known history of abusing children had moved into the house.

There is more to communication, however, than exchanging facts: professionals must also be able to process the information they receive and work effectively with colleagues in other services. Sinclair and Bullock noted a lack of inter-agency working in 17 cases. Why is effective communication so difficult to achieve?

Practical difficulties

Firstly, there are practical problems arising from the way services are structured. Lupton et al (1999) found that different working arrangements - such as shift patterns - amongst GPs, social workers, Accident and Emergency (A&E) departments, consultants and nurses created barriers to effective collaboration because it was difficult for individuals to meet or talk on the telephone at a time convenient for all. Other practical considerations are said to be the constant round of local government and health service reorganisation that can lead to confusion. A lack of staff and inadequate resources in both health and social care agencies can cause overwork, high levels of staff turnover and the inevitable use of agency staff which can be responsible for staff 'burnout'. In a study of professional groups working with children and families, Easen et al (2000) found that the different conditions under which they worked had an impact on collaboration. These included their statutory responsibilities, the availability of time, personnel and other resources and the nature of management structures. There were more subtle factors, however, such as the perceived status of

different professional groups, which interacted with these structural factors making it difficult for researchers to unpick their effects on collaboration more generally.

Role confusion and professional conflict

A lack of clarity about roles or duplication of tasks were found to be a key factor in eight of the 32 child abuse Inquiry reports reviewed by Reder et al (1993) and has been noted in a number of other studies (e.g. Hallett 1995). Sinclair and Bullock (2002) refer to a poor understanding of roles and responsibilities in respect of confidentiality, consent and the process of referral. Misunderstandings can lead to mistrust between professionals (Brandon *et al* 1999) and, as discussed above, the Climbié report highlighted how misunderstandings and role confusion between health and social services staff were instrumental in failing to protect Victoria.

The ways in which health and social care staff are trained or subsequently learn to perceive their roles may contribute to the problem. In a study of the role of health professionals in the child protection process, Lupton et al (1999, 2001) identified a tension between the '*traditional preventative and curative role*' of nurses compared to the '*more investigative role*' of child protection social workers and the police although there was also a view amongst health staff that social workers' higher thresholds for intervention made them slow to act. The difficulty in reaching an agreed definition of neglect and emotional abuse was also mentioned by respondents as something that could cause conflict between members of staff from different agencies.

Another difference in approach was that social workers and health visitors were more likely to take account of a child's family and social circumstances while paediatricians disengaged from the assessment if they felt they had nothing to contribute medically. The authors found that doctors were less likely to take account of local or national guidelines, arguing that flexibility which allowed for professional autonomy and 'clinical freedom' was more effective in child protection than rigid procedures. Blyth and Milner (1990) argue that 'the only effective way forward is to begin to pay attention to the process of partnership and to be a little less bound up with procedures and power'.

Culture and power

The stereotyping of other professional groups is likely to be prevalent when they meet or communicate relatively infrequently (Blyth and Milner 1990). This may be exacerbated by perceived differentials in power and status within and across agencies, particularly the unequal relationship between social workers and senior medical staff (Birchall and Hallett 1995; Morrison 1998; Hudson 2002; Reder and Duncan 2003, 2004).

A search for solutions

Structures vs. relationships

On a practical level, data management systems which are widely used and understood aid collaboration and allow individuals to make contact easily despite

not being geographically close. This may not be the whole answer. A key precondition for effective collaboration is that individual members of staff understand and feel confident about their role and functions (Blyth and Miller 1990) and are therefore clear about their responsibilities. Unambiguous lines of accountability are needed. Training - including multi-agency training - is necessary and can have the added benefit of bringing staff together and thus providing '*the solution to overcoming negative stereotypes*' (Goveas 2005).

Easen et al (2000) suggested that the 'cultural differences' between professional groups could be broken down by staff knowing others at a personal and informal level and having active networks. The role played by key individuals who were skilled in working across boundaries was seen as an important factor in encouraging co-operation. Reder and Duncan suggest that to improve services individuals should learn to think and communicate effectively and that structures are less important than the interpersonal skills needed to take on a 'communication mindset'.

> *Effective communication is the responsibility of both the message initiator and the receiver and, as such, it is a mindset and a skill that can be learned, rehearsed and refined. Only then will policies and technological aides have their optimal benefit* (Reder and Duncan 2003).

A number of writers support this suggestion that bureaucracy is not the answer. For example, the failures identified by the Laming report suggest:

> *…not a need to restructure or the need for yet another form, but a need to re-establish the inquisitiveness and moral responsibility that social work used to take for granted* (Raynes 2004).

An acknowledgement of different perspectives is more helpful than an attempt to ignore conflict and can lead to healthy disagreement, allowing a broader understanding of a child's circumstances and preventing collusive relationships.

In a study of partnership working between health and social care agencies (Davies and Connolly 1995), nurses and doctors placed a high value on social workers attending ward meetings on a routine basis and being readily accessible to health colleagues. The quality of out-of-hours provision was also considered important as was a willingness to be flexible. Nursing staff in the A&E department valued the social workers' input both for their skills in explaining child protection procedures to families and for their ability to network with various other agencies. They also used the social workers as sounding boards, and as a source of support in this stressful area of work.

Hospital social workers – bridging the gap?

Personal contact is thus one of the most important factors in effective collaboration. There is no substitute for constructive relationships between professionals, and co-location can greatly facilitate their development. A consultant paediatrician and named doctor for child protection in a south London hospital states the obvious advantages of having social work teams on site (Hopkins 2003). These are both practical and interpersonal - for example, not spending hours on the phone trying to locate the relevant social worker and

simply being present to build relationships with health service colleagues. Social workers and health workers based in the same building obviously have greater opportunities for informal as well as formal discussions and for sharing concerns:

> *We have 30,000 children coming through casualty a year. If we have a child with child protection issues it's much easier to liaise with our teams based here (*Hopkins 2003)*.*

Bob Hudson at the Nuffield Institute also found that co-location provided a basis for joint working, increasing the frequency and quality of information sharing and allowing a dialogue to develop based on relationships of personal respect and trust, despite differences of professional status and training:

> *While formal procedures were still adhered to, they were modified by these relationships – in effect a shift was taking place from hierarchy to network (*Hudson 2002).

On a cautionary note, the Laming Inquiry highlighted the need for the role of hospital social workers to be completely clear in order to ensure that their presence does not add to confusion.

Many social services departments have withdrawn childcare social workers from hospital settings over the last decade or limited their role to children who live in their local authority area, reducing their ability to be active players in the working life of the hospital. As this review has demonstrated there may be problems with communication, power imbalances, accountability, conflicting priorities and clashes of professional judgment between hospital and social work staff. All of these can have an adverse effect on professionals recognising when there is cause for concern, making appropriate referrals for safeguarding inquiries or assessment, and agreeing and implementing plans. The *National Service Framework* (NSF) *for Children, Young People and Maternity Services – Standard for Hospital Services* (Department of Health 2003) requires hospitals to examine whether they are meeting the holistic needs of the children in their care. It takes a clear position on how this can best be achieved:

> *The best practice occurs when health care professionals know social services staff at a personal level, so that professional trust builds up over time. This can be achieved in various ways. The preferred option is to have a core of social service staff permanently dedicated to working with hospital services and having a base in the hospital, to enable them to provide a rapid service to children and families whilst in hospital. Other models can work effectively as well, but all need an expectation of working relationships that involve trust and respect between professionals.*

The legal and policy framework

Legal relationship between hospitals and local authorities

Until 1974 hospitals employed their own social workers. These posts had their origins in the role of hospital 'almoners' who had responsibility for ensuring that patients had sufficient resources. As a result of the Seebohm Report (Home Department 1968), the Local Authority Social Service Act 1970 required each local authority to establish a social service committee and a Director of Social Services to manage the various social care functions previously provided by a range of departments. Subsequent legislative changes led to responsibility for hospital social workers transferring into the new local authority social service departments.

The NHS Act 1977 section 28(3) further defined the legal relationship between hospitals and social service departments by stating that the local authority must make social workers available to health authorities in its area 'so far as is reasonably necessary and practicable to enable health authorities to discharge their functions under the Act'. This did not make any distinction between those patients who lived within the local authority boundary and those who did not and this has led to difficulties for local authorities with specialist hospitals serving a wide geographic area. Neither did it specify *how* these workers were to be made available – whether located within the hospital or elsewhere - or the nature and number of the social workers required. These matters were left to the local authority and many have decided to withdraw social work teams from the hospitals and provide a service from the local social services office. This has particularly been the case within children's services.

Legal responsibilities towards children

There is a legal expectation that anyone whose work brings them into contact with children and families has a duty to work together to promote children's welfare and protect them from harm. Local authorities, and particularly children's social services[1], have a lead role but it is recognised that they cannot meet the needs of children alone. Specific duties are given to other agencies, including National Health Service (NHS) Trusts to support them. Key aspects of the legislation are as follows.

Children Act 1989

The Children Act 1989 sets out the main duties of agencies to safeguard children.

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[1] As a result of the Children Act 2004, local authorities are now required to establish Children's Service Authorities (CSA) to bring together their functions in relation to children, including social care and education services. The term children's social services is used in this paper to describe the section within each CSA that leads on safeguarding and promoting the welfare of children in need.

- *Section 17* gives every local authority a duty to safeguard and promote the welfare of children within their area who are 'in need'. Assessments of need are usually undertaken by social workers specialising in working with children and families.

- *Section 47.* Where it is considered that a child is suffering actual or likely significant harm, the local authority should initiate enquiries to decide whether they should take action to safeguard or promote their welfare. This relates to children who 'live or are found in their area'.

- *Section 85* requires a health authority providing a child with accommodation for a consecutive period of at least three months to notify the responsible local authority so that they can take steps to determine whether the child's welfare is adequately safeguarded and promoted whilst s/he is accommodated.

Children Act 2004

The Act is designed to ensure that services are better integrated in order to improve the outcomes for all children and is part of the *Every Child Matters* policy initiative (see www.everychildmatters.gov.uk). It created additional requirements for agencies to work together in order to safeguard and promote the welfare of children. This includes the mandatory representation of NHS trusts on the recently established Local Safeguarding Children Board (LSCB) for their area (Section 13) and the requirement that all NHS trusts should have regard to the need to safeguard and promote the welfare of children (Section 11).

Safeguarding policy

Working Together to Safeguard Children 2006

This document sets out how all agencies and professionals should work together to promote children's welfare and protect them from abuse and neglect. It is supported by *What to do if you're worried a child is being abused* (DH 2003a) which focuses on the actions that should be taken when any professional or agency has concerns. Both documents clearly state that all health professionals have a key role in safeguarding children and that this responsibility takes precedence over their obligations to parents.

Health agencies

Each Primary Care Trust (PCT) is responsible for identifying a 'designated doctor' and a 'designated nurse' to take a professional lead on all aspects of the health service contribution to safeguarding children across the PCT area. In addition, each NHS trust should identify a 'named doctor' and a 'named nurse or midwife' who will promote good practice within the trust, provide advice to fellow professionals and conduct internal case reviews. The Royal College of Paediatrics and Child Health has produced guidance on the role of designated and named doctors emphasising the importance of the task and recommending that sufficient status, time and resources be provided to enable them to fulfil their responsibilities adequately (RCPCH 2005).

Working Together states that

- all hospital staff should be trained in how to safeguard and promote the welfare of children, be alert to potential indicators of abuse or neglect and know how to act upon their concerns in line with local LSCB procedures;

- staff in A&E departments should be able to recognise potential safeguarding concerns, and know how to find out if a child is subject to a child protection plan;

- specialist paediatric advice should be available at all times and to all relevant units;

- the need to safeguard children should be considered when parents seek help for their own medical needs, or where children experience repeated minor injuries;

- staff should act upon their concerns i.e.

    o refer to children's social services and confirm in writing within 48 hours;

    o hospital consultant, examining doctor and senior ward nurse to participate in strategy discussion;

    o provide relevant information and contribute to any assessment/ enquiries as required;

    o participate and provide relevant information to any child protection case conference;

    o undertake any additional tasks specified within the child protection plan.

In order to supplement *Working Together, a*n inter-collegiate document has been produced on the roles and competencies of health staff in safeguarding children (RCPCH 2006).

Children's social services

Where a child is at risk of significant harm, children's social services staff are responsible for co-ordinating an assessment of the child's needs, parenting capacity and the wider family circumstances. Where actual or likely significant harm is suspected, they should undertake Section 47 enquiries to decide whether the local authority should take action to safeguard the child and

- if necessary, act quickly to secure the immediate safety of the child;

- convene a strategy discussion with the police and other agencies, including the child's hospital consultant, examining doctor and senior ward nurse if they are an in-patient, to determine how the assessment will proceed;

- lead a Core Assessment, with co-operation from other agencies, to determine what action is needed to safeguard the child;

- convene a child protection case conference if it is judged by the agencies most involved that the child may suffer significant harm;

- if the conference decides the child needs to be the subject of a child protection plan, a social worker should be appointed as key worker.

The National Service Framework for Children, Young People and Maternity Services (2004)

This is a ten-year action plan to promote the health and well-being of all children. There are three standards which are particularly relevant to this topic.

Standard 5: Safeguarding and Promoting the Welfare of Children and Young People

This emphasises that, at a strategic level, all agencies working with children should prioritise safeguarding and promoting the welfare of children and young people, and that this commitment should be reflected in local policies and procedures. Staff are expected to be proactive and alert to the needs of particularly vulnerable groups. For example, health staff may be particularly well-placed to identify children abused through prostitution or harmed through induced or fabricated illness or to recognise the risk of harm to unborn children.

Standard 7: Children and Young People in Hospital

This standard sets a model for the care of children and young people when they are in hospital. It states that Acute Trusts should ensure that all staff are aware of their corporate and individual responsibility to safeguard children and supported to fulfil their role through access to training, advice and clear procedures. The hospital trust board should be kept fully informed about the trust's performance in relation to child protection and should have links both with the LSCB and local PCTs for the purpose of strategic planning, and to discuss complex or difficult cases.

Standard 11: Maternity Services

This standard expects maternity services to be proactive in engaging women from disadvantaged groups early in their pregnancy and maintaining contact before and after birth. It also notes the importance of engaging with fathers and partners. Where women have mental health or substance misuse problems or are experiencing domestic violence, professionals should consider the effect on the woman's ability to meet the needs of her baby and refer to social services for assessment where there is cause for concern. In order to support this, maternity and social services should have joint working arrangements in place.

In order to support the implementation of the NSF standards, a competencies framework is being developed by Skills for Health (www.skillsforhealth.org.uk). Competence CS10 relates to safeguarding children and young people at risk of abuse and CS6 relates to discharge planning. It was planned to link these competencies to those within the Common Core of Skills and Knowledge for the Children's Workforce but this is proving complex to achieve (Skills for Health 2006).

Inspection arrangements

The Healthcare Commission

The Healthcare Commission (formerly known as CHI and CHAI) has a specific statutory duty to safeguard and promote the rights and welfare of children. It

takes account of the NSF standards in its regular inspections of health and social care organisations and can undertake themed inspections. The Commission asks boards and senior staff of all the NHS organisations in England to complete an annual self-assessment of child protection services.

Commission for Social Care Inspection (CSCI)

The Children Act 2004 introduced a new Framework for the Inspection of Children's Services. Children's social care inspection is currently undertaken by CSCI but this responsibility will shortly transfer to Ofsted. Each local authority must undertake an annual assessment of its own performance (APA) in relation to children which will contribute to the overall Comprehensive Performance Assessment (CPA) of their council.

Joint Area Reviews

A three year programme is in place to inspect all local services for children through a Joint Area Review (JAR) conducted by multi-agency teams of inspectors from Ofsted, CSCI and the Healthcare Commission. They will consider all local services for children and draw in information from other inspection processes. The criteria for these inspections are based on the five key outcomes for children defined by Every Child Matters and draw on the standards and guidance established by the NSF, Working Together and the Assessment Framework. The task of the JAR in relation to safeguarding is to consider how far local services contribute to children and young people staying safe. The most relevant aspects of the key judgements for this report are contained within section 2.4 and include standards for

- policies/procedures;

- training and staff support;

- recording and information sharing;

- agency accountability.

They also require that threshold criteria for making and responding to safeguarding referrals are clear and widely understood.

From theory to practice

It could be argued that, with the plethora of policy, procedure and guidance, harm to children should be avoidable. All staff should be aware of their roles and responsibilities and working in partnership to safeguard children. Yet things continue to go wrong and recent inspections have raised concerns about safeguarding arrangements.

Findings from inspection

Before the Inquiry into Victoria Climbié's death had reported, *Safeguarding children: a chief inspectors' report on arrangements to safeguard children* (DH 2002) found differences in the way agencies interpreted their safeguarding responsibilities, tensions between agencies and confusion about when to share information or make referrals. Following the Climbié report, the key agencies of

health, social services and police were required to audit their safeguarding arrangements in the light of the recommendations. The results identified a lack of focus and operational difficulties at all stages of the process. The Secretary of State for Health also requested inspections of the child protection systems in the four council areas where there had been some professional contact with Victoria, namely Brent, Ealing, Enfield and Haringey. The subsequent inspection reports identified continuing difficulties in relation to the interface between hospital and social services, in spite of improvements (SSI 2003a; SSI 2003b; SSI 2003c; SSI 2003d). These difficulties ranged from a lack of trust between hospital staff and social workers, perceived delays in response from social workers, high turnover of staff within social services, failure of hospital staff to recognise child protection concerns, lack of operational protocols, and delays in getting written reports from hospital staff.

Attempts have been made to address many of these issues but the second joint Chief Inspectors' report on arrangements to safeguard children (CSCI 2005) identified ongoing problems:

- although most NHS organisations have child protection procedures, it is unclear whether they are put into practice and monitoring is inconsistent;

- agencies other than social services are often unclear about how to recognise the signs of abuse or neglect, are uncertain about the thresholds that apply to child protection or do not know to whom they should refer;

- some councils apply inappropriately high thresholds in responding to referrals and in taking action to protect children;

- because some social services departments are unable to respond to families requiring support, other agencies do not refer children when concerns about their welfare first emerge;

- there is a lack of clarity about what information can be shared or reluctance to share it;

- there are a lack of robust protocols for ensuring that hospital staff notify social services about children who spend more than three months in hospital to trigger an assessment under Section 85 of the Children Act 1989.

Comment

It is clear that joint working is easy to theorise about but hard to achieve. The drive towards integration as a result of the Children Act 2004 was designed to facilitate communication but it is not obvious how hospitals and social services will come together within these integrated arrangements, particularly as some hospitals have access to on-site children social workers and some do not. The three models of joint working described in the Every Child Matters guidance (www.everychildmatters.gov.uk/deliveringservices/multiagencyworking) are multi-agency panels, multi-agency teams and integrated teams. None appear to fit the provision of a social work service for children in hospital. This study has attempted to cast some light on the reality of working arrangements and the findings are described in the following chapters.

Working arrangements between hospitals and children's social services

Survey findings

Parallel surveys were undertaken of social service departments and NHS Hospital Trusts in relation to their joint working arrangements (see Appendix 1). There were 51 respondents from social service departments, responsible for providing a service to 85 local hospitals, and 42 from hospital trusts which referred to 63 hospitals. There was little direct overlap between social services and hospital respondents so, in all, information was available on 130 hospitals. Responses have been combined unless there were particular disparities. The following picture emerged about working arrangements and the key issues for staff.

Social work service to hospitals

In order to map the way that services were organised, social services respondents were asked how they provided a children and families social work service to the hospitals within their local authority area, where this service was based and who managed it. Respondents reported that in 40 hospitals (47 per cent) the service was provided by hospital-based social workers, and in 41 (48 per cent) by social workers working from local area offices; four (5 per cent) had social workers working across both hospital and social services sites. This picture of about half of hospitals having on-site social workers (49 per cent) was reflected in the responses from hospital trusts. Three models for the provision of a social work service to hospitals were identified:

Model 1

No hospital-based social workers and service provided by children's social work team from local area office.

Model 2

Children's service social worker(s) based entirely on hospital site. Most structural links were with the local children's services assessment team, but others were with a specialist health or disability service.

Model 3

There were a small number of hospitals with hybrid arrangements. For example, one hospital had a social worker based on-site who was managed by a senior nurse. In another, the social work team was part of a wider multi-disciplinary psycho-social service with dual lines of accountability.

In those hospitals with on-site social workers, in some cases this was an entire team, possibly including additional specialist posts funded by the NHS or voluntary sector; in other cases there were only one or two workers out-posted

part or full-time to the hospital This variation is reflected in the fact that only 35 per cent of social services respondents reported that hospital-based staff had an on-site manager permanently located there. Some respondents made reference to on-site senior practitioners or assistant managers having partial management responsibility to fill this gap.

Working in partnership

As discussed above, effective communication between professionals is a key component in safeguarding children. Respondents from both social services departments and hospitals were asked whether there were policies, protocols or mechanisms in place to promote communication, develop strategy and improve services for children in hospital settings.

Strategy and service improvement

The majority of respondents described a range of meetings or other fora focusing on child protection but a worrying minority said that there were no mechanisms in place. A key opportunity to determine both strategic and operational activity was the Area Child Protection Committee (ACPC) and its subgroups, which included ones focusing on health, audit and information, multi-agency practice issues, reviewing referrals from A&E, serious cases, training, Laming implementation, quality assurance, and policy and practice.

Other local mechanisms for developing strategy and improving services reported by respondents included monthly Adolescent Link meetings, a 'drugs in pregnancy' steering group, clinical governance meetings and children's health steering group meetings. One local authority reported on two local multi-agency conferences which had promoted closer working between agencies including the setting up of a number of working groups. One hospital trust held bi-annual meetings of health professionals with designated responsibility for child protection and senior social work managers.

Opportunities to discuss cases

Asked whether there were arrangements in place for social work and hospital staff to discuss specific cases, again a large majority of respondents said that there were. A number of different arrangements for communicating across disciplines and teams were described, with local decisions having been taken about the most effective methods. For example, one respondent reported that there were no formal ward meetings because these were not seen as making the most efficient use of staff time but there were daily A&E liaison meetings and a variety of planning meetings at this hospital. Types of meetings included:

- Ward meetings. Respondents mentioned regular (daily, weekly or fortnightly) psychosocial meetings in the hospital which were commonly held on paediatric wards and attended by a multidisciplinary team.

- Accident and Emergency (A&E) liaison. In some settings, these took place daily to review children who might be a cause for concern following their own or a family member's attendance at A&E.

- Speciality meetings focusing on a particular service - such as maternity services, intensive care or oncology.

- Regular liaison meetings between senior social services and hospital staff. For example, one hospital held regular multi-agency meetings at which particular cases were reviewed. These were commonly chaired by the named nurse or midwife for child protection and included representatives from social services and the police.

- Case planning meetings. Other meetings were convened on a case-by-case basis. In one hospital, for example, a multidisciplinary meeting was held if a child died in order to co-ordinate bereavement services for family members. In another, a respondent noted that meetings held at the discharge of a complex case were chaired by a senior social work manager.

Regular communication with social services staff was not the norm at all hospitals, however. One respondent noted that meetings were arranged as required but only if the circumstances were 'really pressing' and two others noted that there were 'no specific mechanisms' for discussion. Staff in hospitals where social workers were based on site were more likely than those without to have opportunities to meet regularly to discuss cases. At one hospital the on-site social worker attended ward rounds three times a week and on two days referred to a 'communication book' and talked to staff about particular children and their needs.

Working relationships between hospital and social services staff

Respondents in hospitals were asked if hospital staff were able to discuss child protection concerns with and seek advice from social services staff informally. Thirty-three (79 per cent) replied that they were able to but others reported that it was 'difficult' or 'very difficult' to make contact with a social worker for an informal discussion. For example, one respondent thought that the system of using interviewing officers rather than social workers at referral stage made it impossible for paediatricians to seek informal advice from a qualified practitioner. Other problems mentioned were: the lack of a 'relationship' between hospital staff and any one social worker; difficulties in contacting social work staff, particularly out of hours; poor responses from out of county teams and the fact that a helpful response was dependent on the 'experience, knowledge and motivation' of particular social workers.

Those working in trusts where there were hospital-based social work teams were more likely to seek advice. Many said that it was 'easy' to have informal discussions in the hospital but that - as one put it - 'response varies with local area teams'. Staff might be more willing to approach an on-site social worker because they know him or her. One respondent said that staff found the hospital worker a 'useful resource' for informal discussions but that they 'felt less able' to contact someone they did not know. At the time of completing the questionnaire, the social worker based at this hospital was on maternity leave which meant that fewer informal discussions took place. Two respondents mentioned having 'no name' discussions with social workers to assist risk assessment. However, some respondents pointed out a risk arising from informal discussions: there could be confusion regarding the process by which discussions became referrals and assumptions could be made on both sides leading to misunderstandings. They considered that the process should be formalised to avoid these.

Access to the child protection register

Respondents were asked whether hospital staff had access to the local authority area child protection register and, if so, how this operated. The meaning of 'access' was not defined and respondents interpreted this in different ways. Thirty hospital respondents (71 per cent) described themselves as having access, 11 (26 per cent) that they did not. However, when asked about arrangements for access, two-thirds said that access was by telephone either via hospital social workers, the local team's duty social worker or the out of hours emergency team. There were a number of other arrangements. Some, for example, said that a copy of the register was held in hospital but access was limited to named staff in the A&E and paediatric departments. Others reported having electronic access (one mentioned the SWIFT system) or said they were in the process of getting online access. Some mentioned that they had a system for highlighting the names of children who appear on the register on the patient administration system. One respondent noted that local PCTs and Acute Trusts previously did have direct access to the child protection register but this was curtailed after discussion at the ACPC. Another said there had been 'considerable debate' about the risks and benefits of online access and practice where every child attending A&E is checked on the register.

Social services respondents were more optimistic about their local hospitals' access to this information, 47 (92 per cent) reported that they did have access. This reduced, however, for other hospitals used by the population but not based in the local authority area: only 36 (71 per cent) said those hospitals had access and 12 (23 per cent) that they did not.

Responding to concerns about a child

A system for referring children to social services that is clearly understood by hospital staff is key to effective joint working. Social services respondents were asked how they would respond to a child protection referral arising from a hospital setting. Twenty-nine respondents (57 per cent), reported that it would be the responsibility of the local assessment team while 11 (22 per cent) said that hospital social workers would undertake enquiries. In some settings, the referral would be made to the local helpdesk, but might then be channelled back to the hospital social worker for investigation following a decision by the team manager.

Even where hospital social workers were responsible for undertaking enquiries, there were caveats. These could relate to the availability or capacity of a hospital social worker but there were a number of other boundaries to the role which are explored more fully when considering the role of hospital-based social workers below.

Making a referral to social services

Respondents from social services were asked whether they thought that hospital staff in their area understood how and when to make referrals. Forty-five (88 per cent) answered 'yes' although some went on to qualify this by saying that particular hospitals or wards had a greater understanding than others. One admitted that '*some wards have closer links and more productive relationships*'

and gave the example of maternity staff. When hospital respondents were asked the same question, only 29 of 42 (69 per cent) thought staff found it 'easy' to decide when to refer.

A number of respondents mentioned a need to support the process through supervision, advice, training, clear procedures and multidisciplinary meetings. The presence of social workers on-site was thought to be helpful because information was regularly reinforced by social work staff attending meetings at senior level, and because social workers had a role in providing written information and training for hospital staff. They could also participate in decision-making about referrals. One said that having social workers in the hospital provided '*excellent support in offering advice and guidance either informally or formally*' while another said that making a decision was not always as easy as it had been in the past when there was a dedicated social worker who was used as a point of contact.

Where social workers were *not* on-site, hospital staff turned more to their own resources relying more on named professionals, who provided advice, training, information, procedures and ongoing liaison and communication. Cases that were not 'clear cut' could be discussed with these specialist colleagues and one respondent described how their trust child protection support service worked hard to create an open atmosphere that encouraged staff to discuss concerns. Two full-time child protection specialist nurses were kept fully occupied at this hospital with answering queries, facilitating responses for children and young people, and providing training.

Where the picture was less positive, difficulties included some confusion about roles and responsibilities. One social worker, for example, said that '*many wards seem to think social work is solely for advice on benefits, housing and access to charities*'. Other problems raised were a lack of suitable referral forms (or forms that were too long and therefore not used) resulting in missing information. One respondent noted that hospital staff '*probably refer late and under refer*' and that not all verbal referrals were followed up with written ones. Two respondents also pointed out that as no data were available on cases that were *not* referred it was impossible to be sure whether all cases were referred that should be. Difficulties were also described in relation to specific types of concern. In one area it was felt that child protection referrals were understood but that some work was required on devising common thresholds for other needs. Others thought that it was more difficult for staff to decide to refer in cases where the concerns were regarding neglect rather than injury or that clear guidance was needed on referring young people (especially those aged 14 to 17) in relation to alcohol consumption, sexual health, drug experimentation and behavioural difficulties.

Overall the findings suggest that knowledge about when and how to make referrals is not always consistent across all wards and departments and that a continual process of discussion, information sharing and training is necessary to ensure that this knowledge is up to date. Social services were not fully aware of this difficulty and overestimated the confidence of hospital staff.

Responses to referrals

A slightly different picture emerged when hospital staff were asked to comment on their experience of receiving a response to their concerns from social service departments. Only 15 (36 per cent) reported that arrangements worked well and there were some caveats to these positive responses. A larger number stated that they found getting a response 'difficult', 'poor' or 'variable'. Some said that a prompt response was received from hospital social workers but that from local area teams response was were 'patchy'. Other problems mentioned were the lack of feedback on assessments from social workers; poor liaison on ongoing cases; slow written responses despite timely verbal ones; a less efficient response to Section 17 concerns compared to Section 47 ones; inconsistency of response and a poor response out of hours, if a child was not already known to social services or was from another local authority. One reported that discharge from hospital could be 'significantly delayed' if social workers did not respond promptly. A respondent from a children's hospital pointed out that the quality of responses to referrals could have an effect on reporting because hospital staff tended to be 'put off' if they did not receive a positive response to concerns and that this could have an effect on future referrals.

The role of hospital-based social workers

Social services respondents who had hospital-based social workers (including those where the social workers were not full time in the hospital) were asked to provide information about their role.

It is clear that the role of hospital social workers differs between local authorities and even between hospitals within authorities. Some concentrate on assessment and short term intervention, such as taking referrals, undertaking child protection enquiries (particularly for unborn children), and initial legal proceedings. Others undertake longer-term work for children, including acting as a key worker for children on the child protection register or looked after children. In five cases reported by respondents, this extended to long-term support for children in the community. One noted that there was a move to pass long-term cases to the area based social work team so that hospital social workers could begin to develop specialisms. Local decisions appear to have been made about the best use of their time with a range of operational boundaries being used to limit eligibility:

- whether the child is in the hospital or community;

- whether the child is an 'open case' to their service or another team;

- the nature of the assessment, with some workers undertaking initial rather than Core Assessments only;

- child who is the 'patient' only or the whole family, including siblings;

- the extent and type of legal intervention required;

- timescales for retaining case responsibility;

- nature of child's condition;

- nature of the problem.

For example, some respondents reported that hospital social workers would complete an Initial Assessment if the child was known to them and/or was an inpatient but that otherwise the area assessment team would take the referral. Another noted that, although the hospital social work team would carry out an investigation, their involvement would cease at the next stage e.g. at a Child Protection Core Group meeting or at a Looked After Child First Review when responsibility would be passed to the appropriate area team. In complete contrast, some specialist social workers did not undertake any 'statutory' work but would work long-term with children with chronic illness. Where other teams were undertaking the work, it was common for the hospital social work team to act as a conduit for information: a role questioned by Lord Laming.

Children from other local authority areas

The most significant operational boundary was the service provided to children from local authorities other than that where the hospital was based. Most hospital social workers provided no service at all or limited the service to taking referrals and short-term/ emergency interventions and would expect the child's home authority to take responsibility, unless the child had a medical condition warranting support from a specialist social worker, such as CLIC Sargent, when geographical boundaries did not apply. Most social workers did, however, provide a liaison role between other authorities and medical and nursing staff and, sometimes, with the family e.g. '*the team is often in the position of facilitating information gathering particularly for the police in these situations*'.

Providing training and information

Most hospital-based social workers (including those based on site part of the time) had a role in providing formal or informal training for hospital colleagues. This included formal child protection training, induction training for new staff and trainees as well as a range of informal training and/or information giving on topics such as assessment and interventions, looked after children, the psychosocial effects of diagnosis and illness, and external agencies.

Allocation of work

A further question asked how hospital social workers were allocated their work and whether they operated a referral system. Most reported that referrals were made through a duty system operated by the hospital social work team but in a couple of settings, referrals were made to the authority's assessment service or helpdesk and then channelled back to the hospital social worker. A minority of social workers took referrals directly from the wards or multidisciplinary teams to which they were attached.

Most social workers held mixed caseloads but there were a number of workers with a specified role who worked only with certain children (e.g. specialisms in neonatal, mental health, palliative care and oncology). It was clear that this was sometimes related to funding, with some social workers being employed specifically to provide a service to children with a particular illness. The CLIC Sargent organisation is particularly active in funding specialist social workers to work with children with cancer.

Reciprocal arrangements between local authorities

Social services respondents were asked what reciprocal arrangements were in place with other local authorities. It was a clear recommendation of the Laming Report that protocols should be developed regarding the social work service to children in hospital from other local authorities but this did not seem to have been fully implemented. Twelve (23 per cent) responded that there were no formal arrangements, two (4 per cent) did not know and five (10 per cent) did not answer this question. Of the others, two mentioned the all London child protection procedures and two said that arrangements were negotiated on a case-by-case basis. Others mentioned local agreements and procedures which included the host authority taking on some assessment while also making a referral on to a child's resident local authority, acting as a conduit between authorities, historical agreements which were no longer effective, and new procedures in the process of development. However, the absence of formal arrangements did not mean that social services staff would not act. One respondent was explicit about their responsibility:

> *[The authority] will carry out Initial Assessments and Section 47 investigations on behalf of other local authorities. [The authority's] primary concern is the child's safety as opposed to which local authority has responsibility.*

Children in hospital for longer than three months

All respondents were asked how they fulfilled their responsibilities under Section 85 of the Children Act for children remaining in hospital for longer than three months. The fact that most children return home for periods of time and therefore break their stay in hospital means that this occurrence is rare. Eight hospital respondents admitted that, because of the rarity of such cases, procedures were not robust for ensuring that these children are referred to social services and staff's understanding of their duty to inform social services was sometimes patchy: they believed that this was an area of work that needed attention. Other respondents did mention mechanisms for informing social services which might be via a liaison health visitor or the consultant responsible for the child's health care. In hospitals where there were social workers on site, it was reported that the circumstances of children in this category would be relayed to social work staff at meetings or during ward rounds and social workers would then ensure that the child's home authority was informed. It was often unclear whether this expectation was formalised or assumed. There also seemed to be some confusion about what should then happen. Two mentioned that such a child would be treated as a 'child in need' and two more reported that a strategy meeting would be organised to review each individual case. Another said that a child in hospital for three months 'would trigger an *Initial Assessment* by social services with a view to a formal LAC review'.

Only a few social services respondents reported that there was an agreed protocol between the hospital trust and the social services department. Most relied on the hospital to inform them of the existence and needs of these children and would respond accordingly when informed. One noted that there was regular discussion about 'chronic cases' but that, apart from neonates, these children

tended to have regular admissions rather than long stays in hospital. Another noted that, although cases were rare, a keyworker would be allocated to a child. Details were also given about procedures followed such as informing parents, arranging review meetings and carrying out assessments.

Conflict over a child's safety or welfare

All respondents were asked how conflict between social services and hospital staff in relation to a child's safety or welfare would be resolved if it occurred. The responses were fairly consistent with most replying that this would be referred to management to resolve through discussion and negotiation and that, if there was no agreement, more senior managers would be involved (up to and including the trust's chief executive or the director of social services, if necessary). Others said that a meeting of professionals would be held involving the designated nurse or consultant paediatrician responsible for child protection on one side and senior social services managers on the other. A number mentioned the use of ACPC protocols in the resolution of disputes.

There were, however, interesting disparities in views as to where ultimate authority lies. One hospital respondent said that the 'ultimate decision rests with social services' but two others said that a consultant paediatrician would take responsibility for discharging a child from hospital – or for taking other action. This view was echoed by a respondent from social services, stating that the consultant paediatrician was responsible for a child's safety at discharge, whilst another said that in the event of any disagreement, a social worker would pursue enquiries on his or her own initiative. Respondents from both social services and hospitals referred to the possibility that advice would be sought from legal services if required and one argued that the trust would consider taking legal action to protect a child if it believed that '*the child was not safe within the arrangements made by the home social services department'*.

Strengths and weaknesses of working arrangements

A final question asked all respondents to comment on the strengths and weaknesses of their working arrangements.

Staff identified close professional relationships, working in multidisciplinary teams, sharing a holistic understanding of the needs of children and young people and their families, communicating well and having an appreciation of each others' different roles and responsibilities as leading to the most effective services. However, they also recognised that individuals cannot be responsible alone and it is the structures and opportunities for learning, communication and planning that underpin good will, commitment and successful multi-agency relationships. Responses are described under the following headings:

- Structures and working arrangements;

- Communication and day to day practice;

- Staff roles and ethos.

Structures and working arrangements

Perhaps the most important of these is basing social workers on the hospital site and involving them in the work of the hospital. According to the survey findings, co-location is perceived as the most effective way for social work staff to develop positive working relationships with their health colleagues, giving both opportunities for joint training, consultation and decision making. From the point of view of hospital staff, the benefits of having social workers on site included opportunities for informal discussion and '*flexible ways of working together*'. One reported that there were clear advantages:

> …*since the hospital-based social worker commenced in post this year, a huge and very positive difference has been commented on by all staff.*

Another noted that the hospital-based team '*respond well to requests for help with children and families who are not known to the social services department*'. Other positive aspects of this working relationship were the participation of social services staff in developing training and procedures and the excellent response of social services to child protection concerns. Having social work managers on-site can add a more strategic element and provide clear direction for the service.

Other structural elements included shared funding, local committees, regular meetings, clear protocols, documentation and lines of responsibility, effective IT and other systems which enable staff to stay in close touch. Two respondents mentioned having jointly developed systems for tracking vulnerable children through a stay in hospital ensuring none 'slip through the net'.

Potential difficulties were the different arrangements developed by different hospitals, diverse management structures, the fact that social workers have to work across a number of Primary Care and Acute Trusts and the lack of procedures for dealing with non-resident children. One respondent mentioned the difficulties of keeping up with the rapid and far-reaching strategic changes that are occurring in hospital trusts. It was also noted that without structures in place to ensure that hospital social workers maintain their links with their area social work colleagues, they can potentially become isolated if working in a small hospital team.

Communication and day to day practice

Effective, regular communication between staff was regarded as important by respondents in order to ensure that staff across all disciplines understood their roles and adhered to the same child protection procedures. Communication was identified as a process that needed to be continuous to ensure that all staff were aware of their own and each other's responsibilities for children's safety and welfare, particularly in teams with high staff turnover. The necessity for ongoing training, discussion and a promotion of the role of social workers to ensure that links remained strong were mentioned by respondents. Personal links developed at ward level between members of staff were described as positive.

Some of the problems associated with communication raised by social services respondents included a lack of understanding of child protection procedures and thresholds on the part of hospital staff, poor links with obstetricians (despite developed ones with midwives) and surgeons, misunderstandings, and hospital

staff not knowing who to approach if hospital social workers were not available. Communication between staff was also identified as a problem for some hospital respondents, for example: '*communication at day-to-day level can be difficult. People are anxious about sharing information across professional boundaries*'.

In general respondents wanted to foster greater understanding between the services which would provide mutual support and a more joined-up service for families. Opportunities to meet informally – '*not just in times of crisis*' – would be welcomed as would joint training. Again, the benefits of hospital social work teams were stressed by a number of respondents.

Staff roles and ethos

It was reported that overwork and high staff turnover in both social services and the health service and the difficulty of recruiting staff were barriers to individuals and teams developing good practice. Overstretched services mean that the potential of joint working is not fulfilled and may result in social workers dealing almost exclusively with 'heavy end' child protection cases rather than being able to provide services for those deemed children in need.

The poor profile of social services amongst families was also seen as a weakness by hospital staff although on-site social work teams were exempted from this negative view by respondents. One respondent provided a clear description of the difficult position faced by hospital staff:

> *There is still a long way to go in terms of the image of social services as perceived by children and families. For example, a health practitioner may have difficulty obtaining consent to refer if the family have a poor view of what social services can offer them. Essentially then we can be placed in the position of being a PR person for social services. Equally daunting is the common response to families of a letter inviting them to a rather remote run-down office for a consultation instead of a more friendly, personal approach. Most of these observations when raised are usually linked to resource deficiencies within the local authority.*

This negative image was augmented by the insufficient response to children in need. One respondent, for example, argued that children can wait for up to eight months for a social work assessment. The case will be closed if there is no active intervention and the whole process has to start again if the child's needs change as is often the case. There is therefore little continuity for families.

Policies and procedures

Local authority and hospital staff have devised a range of local policies, protocols and forms to support their practice. Some have been developed jointly to ease the interface between agencies and to clarify roles and responsibilities: others have been developed by a single agency purely for their own purposes. The range of documents provided by respondents to the survey were as follows:

Hospital Trust Child Protection Procedures

Several hospitals had developed their own procedures for responding to child protection concerns to provide additional guidance to staff in conjunction with local ACPC guidelines. These guidelines were commonly referred to as 'child protection' procedures although some made reference also to children in need. The documents clearly reflect the lessons derived from Laming, with clear directives, for example, about the need for contemporaneous and signed records and the accountability of senior paediatric staff. Many were relatively limited, however, focusing mainly on the process for reporting concerns within a trust and to social services rather than any ongoing role. Flowcharts were commonly used to illustrate this process.

Other guidelines were more extensive, offering prompts to support staff in identifying suspicious injuries and exploring roles and responsibilities much more fully, including involvement after referral to social services. Specific areas where guidance was offered include:

- individual responsibility of health staff to safeguard children;
- checking the child protection register;
- identifying previous hospital admissions;
- history taking;
- discussions with parents/carers;
- obtaining the child's consent to examination;
- considering whether other children in a household may be at risk;
- consulting named nurses and doctors, and other professionals;
- involving senior medical and nursing staff to take clinical responsibility;
- nature of medical examinations and investigation;
- record keeping;
- referring to social services and following up in writing;
- contributing to assessments;
- confidentiality and information sharing;
- attendance at strategy meetings;
- attendance and reports for child protection conferences;
- making police statements;
- preparing a court report;
- discharge arrangements;
- planning and providing ongoing support and protection;
- participation in core groups;
- contact details during and out of hours.

Interestingly, the involvement of social services was sometimes suggested at a late stage in the process, after medical staff had reached a consensus about whether there were or were not reasons for concern. There was some indication that an informal consultation stage with social services was more likely to be written into the procedures where social workers were based within the hospital. Some hospital guidelines included the role that would be taken by social services and police: others focused purely on what hospital staff would do. The role of liaison health visitor seemed to be particularly key in one hospital in flagging up non-urgent concerns and passing them on. There were no on-site social workers in this setting.

One Trust had developed a protocol for auditing the referral process, in conjunction with partner agencies. They looked at the appropriateness and quality of referrals to social services, the degree of joint working between different health professionals and between agencies and the response to referrals.

These protocols and procedures are supported by pro formas, such as referral forms, checklists and audit forms.

Clarification of social work service

Where social workers were based within the hospital, some had developed documentation to explain their role. This included:

- *Criteria for referral.* For example, one team had listed the circumstances in which they considered a child may be in need divided into maternity and paediatric categories. These included situations where a child might be at risk of harm, such as those whose parents misuse drugs or alcohol, and those where supportive services may be required, such as children with a life-threatening illness.

- *Description of social work service to hospital.* Others went further than listing criteria by offering a general description of their service including liaison and development activities.

- *Children with a home address in another local authority.* This was often incorporated in other documents but some had agreed specific protocols about the role that hospital social workers would take in relation to children resident in another authority. These range from doing nothing at all to routinely undertaking *Initial Assessment*s or fulfilling a liaison function. In some cases, these arrangements appeared to have been formally negotiated; in most they were a statement.

- *Assessment under Section 85 Children Act 1989.* A small number of local authorities had developed a specific protocol for undertaking Section 85 assessments. In one hospital, this included separate checklists to be completed with parents and nursing staff; another provided headings for the social worker to identify the effect on the child of the extended hospital stay; others used the Assessment Framework.

Joint protocols between hospital trusts and children's social services.

Only three locations provided specific agreements about how the hospital trust and local social services department would work together in general. For example, one Borough Council and the local NHS Trust had agreed formal liaison arrangements whereby a social work manager would visit A&E, Paediatrics, Children's Ward and Maternity services on a fortnightly basis to '*discuss practice issues, consultation, training, information sharing, confidentiality and any specific issue relevant to improving interagency working and service provision*'.

Most joint protocols related to specific areas of work and were clearly informed by the Laming recommendations, but reflect his emphasis on accountability within rather than across agencies. Although several protocols mention discharge arrangements where there are child protection concerns only one stated that a discussion should take place *between* the senior paediatrician and social services prior to discharge.

Protocols relating to specific concerns

A number of documents were developed to clarify working arrangements in the following areas:

- *Pre-birth assessment.* These were the most common of the specific protocols. Typically, they include the circumstances in which there may be concerns about the welfare of an unborn child, the process of referral to social services, timescales for assessment and decision making, the expectations regarding strategy meetings and case conferences and the process for communicating the pre-birth plan.

- *Substance misuse during pregnancy.* Some authorities include substance-misusing women in their general pre-birth protocols; others have developed a separate protocol. There are variations as to whether all substance-using women should be referred to social services, or whether there should be additional criteria such as a 'chaotic and/or unhygienic lifestyle' or previous child having been removed. There is also considerable variation about the appropriate point to refer, with one suggesting 10 weeks gestation whilst another suggests 22 weeks.

- *Children who self-harm.* Some hospital-based social workers have a role in assessing children who self-harm although there is an expectation that in these cases there will be support from a child psychiatrist.

Other protocols related to:
- domestic violence;
- allegations of child sexual abuse;
- parental mental health problems and child welfare;
- children abused through prostitution;
- psychiatric emergencies in children;
- response to children in hospital for more than 3 months (Section 85/86);

- response to unexplained child death.

Structure charts

Most charts were single agency only, showing how the NHS trust or local authority services are provided. Others indicate ACPC structures, including sub-committees. Only one chart had mapped out how the hospital trust related to the two local authorities it served from a strategic to an operational level.

Statistical reports

Some data on numbers of referrals and assessments are kept but those authorities without dedicated hospital social work teams cannot reliably extract data about which have arisen in hospital settings. Even those with hospital staff sometimes subsume the data under overall activity by the assessment team. It is therefore very difficult to identify the level of activity undertaken in response to concerns arising in hospital and therefore to track the level of need.

Case studies

Case study sites

Three hospitals located within two local authorities (A and B) were selected as subjects of case studies. Arrangements for providing a children's social work service differed between the hospitals. In authority A two hospitals located in different towns were studied: one hospital (A1) received a service solely from area based social workers while the other (A2) had a team of on-site social workers and a team manager. In authority B the hospital studied (B1) had a small number of specialist social workers on site dealing with particular health conditions but child protection and most other referrals were dealt with by area-based social workers.

Interviews were carried out with key personnel in social services, the hospitals and the police service. In all, five social workers (including managers), four doctors (named and designated), three nurses (named and designated) and three police officers responsible for child protection took part in interviews between October and December 2005. Interviews and supporting documents have been analysed thematically. The findings are presented here.

Roles and Responsibilities

'Named' health professionals with a responsibility for child protection

The positions of designated and named doctors and nurses were intended to improve the contribution of health professionals to safeguarding children at both the front-line and strategic ACPC levels (Lupton et al 2001). However, as these writers go on to point out, available information on these posts suggests that they are not as effective as they might be because of a number of constraints including heavy workloads. In one of the local authorities included in this study, for example, the designated doctor was also the named doctor in the hospital where she worked which allowed limited time for both roles. Two of the three hospitals (in different authorities) had had no named nurse in post for some time although appointments had just been made. During the gap, responsibility had fallen on the designated nurse (based in another town) or named midwife but, in one hospital, the absence had coincided with the named doctor taking maternity leave and the withdrawal of the children's social work service from the hospital site. The newly appointed named nurse was part time which was not thought to be sufficient for the volume of child protection work and possibly a reflection of a lack of commitment at trust level to actively promoting child protection practice. Interviews suggested that not having a named nurse in post had had a noticeably negative effect on communication between professionals – both at formal meetings and informally. Regular inter-agency child protection meetings, for example, had lapsed. The absence of a named nurse also meant that nurses and other hospital staff did not have a colleague in the hospital to approach for advice on child protection matters.

Losing [the named nurse] who oversaw a lot of it [child protection], and was the glue and a link, a communication link really between the hospital and Social Services and us, that had a detrimental effect. (Police inspector)

When they didn't have a named nurse in post, things definitely slipped. And we experienced more difficulties, we experienced more hiccups from the hospital side. And I think they've underestimated how much work that nurse does because she's only seconded for 20 hours 'cause they weren't sure how much child protection should be. And we could have told them how much. (Social work manager)

The location of the social work team

The benefits of on-site social workers described by survey respondents were echoed by interviewees. There was a team of social workers and a team manager working on behalf of children located in hospital A2. Interviewees said that one of the advantages of this arrangement was the ease with which health staff could communicate with social work colleagues in relation to both casework and more strategic projects. Informal meetings between the named nurse and social work team manager were held fortnightly, for example, and multi-disciplinary child protection meetings monthly. Staff could also talk face to face between meetings.

The key is communication – and effective communication. Not just communication for the sake of it. From experience, being based in the hospital, it's more effective. That's one of the bonuses (Hospital social work team manager)*.*

Because we are physically just down the corridor [from the social work team] at any point I think, 'oh quite nice just to go and have a face to face discussion', so I'll just walk down, wander down to see them. So I think that proximity really is an advantage (Named nurse for child protection)*.*

The other hospital (A1) in that authority did not have a social work service for children on site but the named nurse had developed a bridging role. This nurse was based in the community and had in-depth knowledge of local families as well as wide experience of child protection work. She visited the hospital daily to liaise with the A&E department about any children who had been seen and kept in close touch with the social work team based in the town. Her role was described as being a 'buffer' between hospital staff and social services and her active response to child protection issues and her ability to initiate contact between professionals were seen by colleagues as invaluable.

If I want to chew something over then I will actually just go and see the [area social work] manager and have a chat. (Named nurse for child protection)

She [named nurse] walks into our office and we just have very informal chats about certain families and what we might do, or we meet once a month and we talk about families or concerns or things that may be child protection, so she is that person really that does that. The relationship is

with her and then she has the relationship with the hospital. (Area social work team manager)

However, it was pointed out that the arrangements in this area were based more on relationships between individuals than on robust systems and that they might fail if the named nurse was absent from work for any reason. This is not to argue that close working relationships are not valuable in child protection work but rather that these should be underpinned by systems which are not over-reliant on individuals. In this hospital, for example, the named doctor did not seem to take an active role in child protection and was perhaps not required to do so because of the efficiency and commitment of the named nurse.

Mechanisms for joint working

Interviewees were asked for their views on other ways of organising services to ensure effective joint working. Suggestions included better use of technology for communicating and record keeping and 'virtual' teams. In one area the development of a centre for the provision of children's services – which included a '*baby A&E unit'* located alongside other services – offered possibilities for joint working. Smaller towns and rural areas might benefit from different kinds of services tailored to meet need.

> *You could have more drop-in set-ups where you had a social worker who had a responsibility to the hospital - or an advanced practitioner probably - to work on those relationships, to make sure those systems are in place and set up. Because I don't think that these days, with the technology we all have, that it's necessary to all sit in the same building, as long as the system is in place in some of our smaller areas.* (Assistant service manager, social services)

Another suggestion that could work for a limited geographical area was a 'hub and spoke' arrangement. The hub would be a large multi-agency team based at the main city hospital which also had responsibility for providing a service to local hospitals. An alternative community solution was suggested by a named nurse who thought that a children's services building could include health, social services and education teams as well as CAMHS and family support services. Housing and benefits advice services and a community police officer could also share space or offer services at certain times. These services could possibly be organised around clusters of local schools. One of the advantages would be the ease of communication between services.

> *And then instead of just writing or picking the phone up, you can just wander round… you wouldn't have all this leaving messages or whatever because you could just literally run round to wherever.* (Named nurse child protection)

Information sharing

The literature emphasises the importance of information sharing in child protection. Again, although co-location makes this easier, respondents described a number of ways that it could be achieved in spite of the challenges presented by issues of access and accuracy. Individuals had developed methods that

suited their working arrangements and were regularly reviewed and amended to make them as effective as possible.

In the hospital where a social work team was located on site, for example, the named nurse held a file which she kept up to date with all child protection cases, adding information from colleagues as it was received.

> *It's not in a place where other people can write in it, which might not be the most efficient way of doing it but it seems to have worked. I always felt, because it's facilitated and coordinated in a central place, that all the information does come in and the staff are well aware they need to feed the information in, so it's an overall picture. I don't know logistically how else to do it because, say for instance if the community midwife rings with concerns, I write that down and then the antenatal clinic ring, and say they've seen this woman, I write that down and it's one place to co-ordinate it.* (Named nurse for child protection)

A named nurse in another hospital had developed a colour-coded system to flag up child protection concerns to staff via medical notes. An orange form is added to the medical notes of a pregnant women whose unborn child is the cause of concern and a blue form is added to the hospital records of children on the local child protection register. These forms remain in the notes (even if the child's name is no longer on the register) and act to highlight concerns if the mother or child access health services at a later date.

> *[The orange form] sits in mum's hospital records - there's a copy in the antenatal ward, there's a copy in the central delivery suite. They each have a folder so if they have a mum in that they have concerns about, they look in the folder and know that this is the plan and what's going to happen when the baby is born and who they need to contact.* (Named nurse for child protection)

A similar system was operated within another obstetric service and was said to work '*really, really well'*.

Social workers based in the hospital were able to read and write in medical notes which was seen by the named doctor as one of the advantages of having social workers on site. The fact that social workers were part of the multidisciplinary team meant that they were seen as 'insiders' and allowed to share the rights and privileges of their health colleagues.

> *It's a matter of trust. It would be surprising, I think, for someone who wasn't on the site and who you weren't familiar with to come and be writing on the medical notes.* (Named doctor for child protection)

Other mechanisms for sharing information were via liaison staff and, of course, at multi-agency meetings which were held regularly at two out of three of the hospitals involved in the study.

> *There are two paediatric liaison health visitors that work in A&E and they are good at spotting cases that need to be picked up, and making sure that things do go in the right direction.* (Named nurse for child protection)

At the third hospital there were hopes that the newly appointed named nurse would resurrect a calendar of regular meetings which had not occurred for some months at the time of the interviews.

Effective working relationships

In addition to the structures that support joint working, interviewees talked about the human interaction needed in order to achieve effective communication between staff working in the area of child protection. Well written, clear assessments were recognised as a positive outcome of good working relationships.

> *Our aim is to complete all Initial and Core Assessments as a multi-agency task. And when we get the process a hundred percent right … it's good. And by that, I mean that the agencies get together, they plan the assessments together, they plan who's going to do what, who's going to provide what information, what's going to be recorded, how it's going to be shared with parents, what involvement children are going to have – and actually really do a robust plan for assessments… If they've done a good plan it's usually done within timescales, it's written up together, there's joint ownership of it and I think they're some of the best assessments that I happen to read.* (Assistant service manager, social services)

One element that contributes to this shared endeavour is regular contact between staff.

> *The key thing is to have a good working relationship. It's much easier to work with people that you know and trust and have worked with before than in difficult circumstances to try and form a relationship with a social worker that you've never met before. And clearly you have a professional responsibility to relate to other professionals. And you do your best to do that, whoever they are. Which is much, much easier, if you can go in and speak to someone that you've met before, and worked with, and done similar work with before.* (Named doctor child protection – working with a hospital based social work team)

> *I've been here when we've had social workers on site as well as the current situation and I would say that actually sharing that information on the whole was easier when there was somebody available locally to talk to, more or less face-to-face really… I think there are three or four different social services teams that we deal with in terms of district based teams and obviously there's more than one or two people in each of those teams, so there's a lot more people to get to know and contact and communicate with.* (Named doctor child protection – working in a hospital without a hospital-based social work team)

However, having on-site social workers did not necessarily result in positive working relationships. It was necessary for individuals across the 'Berlin Wall' to co-operate with each other. One social worker described the difficulties she had faced as a social worker based in a hospital setting.

There is from general nurses on the ward, there's a hostility when we come in, and once you've linked with someone on a case they usually were happy to chat to you. But there's always that slight 'you're on their territory' and I couldn't break through it, they wouldn't let anybody who wasn't medical break through it, it's very difficult. They're all perfectly pleasant people, as soon as you had to directly liaise with them, you could rely on that person to look up and smile at you. But otherwise there's just a wall of suspicion there I suppose, and I think that's extended to everybody. (Social worker)

In one area where the social work team was no longer based in the hospital, relationships were less close than they had been previously but were in the process of strengthening at the time of the interviews because staff had recently worked together on a number of serious child protection cases.

[Casework] fosters good working relationships because you find yourself actually physically having one to one interactions with the medics because of the number of meetings that that generates. And obviously born out of something very negative fosters very good working relationships. (Area social work team manager)

The recent appointment of a named nurse after a long period without one in post was seen as positive by social workers who felt that having a member of staff responsible for liaison was an alternative to having a social work team based in the hospital.

Staff turnover, staff shortages - and the resulting heavy workloads - and shift patterns were all mentioned as counterproductive to building working relationships. These factors meant that both health and social services staff may have contact with a number of different people over the course of one working day and that regular interagency meetings became a luxury rather than a norm.

There is a distinction between working well together during a crisis and maintaining good communication over time.

I think it [communication] works in the initial stages … I think where it gets more woolly for ourselves and for the medics is the longer term: pieces of work that are ongoing… Certainly some of the paediatricians have felt that they've not been kept informed of changes in circumstance for young people, etc. And likewise when there's been ongoing health issues that we've not necessarily heard about as soon as we would have wanted to. And again that is about having the time and the resources to keep that communication going, and some trigger mechanism to do that. (Area social work team manager)

Child protection - everybody's responsibility

The question of individual members of staff being prepared to take personal responsibility for ensuring the safety of children was raised repeatedly in Lord Laming's Inquiry into the death of Victoria Climbié. Those who were interviewed for this study were asked about the mechanisms that hospital staff – including

those in junior positions – could use to express concerns and make sure they were followed up.

In one area the named nurse had produced a leaflet called *Child Protection's Everybody's Business.* One hospital had a trust-wide child protection policy which was accessible on the intranet in two forms. These were the complete policy and an abbreviated version which acted as a simple guide for all staff. The policy reminds staff that child protection is 'everyone's responsibility' and provides guidance on how staff should act if they have a concern.

> *And it makes it very clear the responsibility lies with the person who's anxious about the harm to follow it through to a conclusion, or at least pass it on to somebody else. There's also attached to that a detailed policy about what different people should do: what SHOs [Senior House Officers] in other departments should do, what nurses in other departments should do, what our own SHOs should do, what a consultant should do.* (Named doctor)

However, it may not be easy for a junior member of staff to contradict the decisions of more experienced, senior staff particularly in a hospital where there is a strongly felt hierarchy.

> *Personally, as designated doctor, if I was aware of a situation in which a junior nurse thought she wasn't listened to and there wasn't an appropriate response, I would be very distressed. Because it's not just about giving people individual responsibility but it's supporting individual ability as well.* (Designated doctor)

> *People need to be able to call child protection and they need to be able to do it without feeling there's going to be comeback from their management… So I think that's something that all hospitals have to get right because sometimes people get things wrong and have to be challenged on it really.* (Area social work team manager)

The availability of a named nurse or doctor who has time to discuss concerns and is willing to take staff's views seriously should act to support staff as would the development of an ethos which respects the views of every member of staff. The named nurse in one hospital explained how she discussed this issue in training sessions with staff, reminding them that they did have the authority to contact social services if they had a concern even though others may have dismissed it.

In order to take responsibility staff must also understand the procedure for acting on child protection concerns. Interviewees reported that staff were generally well informed about their responsibilities and how to proceed if they had a concern although social services staff said that health professionals were sometimes frustrated that they had to complete a form rather than simply making a telephone referral. One potential weakness was the fact that specialist medical staff, such as those working in orthopaedics or burns units, may not be sufficiently aware of child protection issues. Similarly those treating adults might not think about the need to safeguard children living in that patient's family.

I can think of one or two instances when more specialist parts of the health service, who don't ordinarily deal with child protection, don't see their prime responsibility as making a referral and not following it through. Expecting us to do as they bid. But I'd say, on the whole, that that was the more specialist areas. I had one orthopaedic surgeon I had a debate with when he had diagnosed a spinal fracture and thought that the diagnosis was quite enough – that he'd told me and that was quite sufficient. When there's a lot more involved than that and I needed a lot more than him telling me in a corridor. (Assistant service manager, social services)

Negotiating thresholds for intervention

As noted in the survey findings, thresholds for referral to social services were not always clear to hospital staff. This is perhaps not surprising as in some cases it was not obvious whether a child was at risk or not and, in these, staff might negotiate about the intervention needed. This is partly due to the complexity of defining child abuse but was also perceived to be a way of restricting demand for social services input. A designated nurse in one area was frustrated that local thresholds seemed to be 'fluid' depending on the resources and workload of social services staff at a particular time. The reluctance of staff to acknowledge this made it difficult for health staff to know when to make referrals. There were two kinds of case which health staff highlighted as particularly problematic: children with a poorly managed chronic illness who were repeatedly being hospitalised and those who had a number of problems but none of them acute if taken in isolation. These children were in danger of falling through the net in terms of child protection because concerns about them did not 'hit' the referral criteria.

> *So when you've got a situation where you've got a child who's got a longstanding disability or additional need, and/or parents with a learning difficulty or a psychiatric need and/or some child protection needs, and the whole adds up to a very worrying picture but the individual components don't meet anybody's thresholds, the [referral form] doesn't reflect that. And because when you submit a [referral form] it goes through all these weird hurdles, it falls at the first post because the children very often don't … meet child protection thresholds and yet health practitioners are flagging up this is a very, very high risk situation.* (Designated doctor)

From the perspective of social services, it was felt that tight thresholds had their uses. One social work manager felt that hospital staff should be made to complete a referral form because this helped clarify the reasons for concern.

> *It does really focus people into what the issues are and the reasons for the referral, because otherwise actually we would be getting I think quite a few.* (Area social work team manager)

Staff described how differences of opinion about a case sometimes arise because of different professional standpoints.

> *We have a very strict threshold criteria… I mean, if it's a pre-birth, we sometimes get differences of opinion between the Drug and Alcohol Team, and perhaps the midwife, and you get referrals through, where they say,*

well, 'things have changed, she's been on methadone for three weeks' but 'hang on, she's got a ten-year heroin addiction before she went on the methadone'. So perhaps Drug and Alcohol may have a more optimistic picture, 'cause they're looking at the adult and they're making fantastic progress but the midwife might say, 'well, actually I'm really worried because this is very early days, and we have to think about the baby'. So you get those sorts of conflicts arising. (Area social work team manager)

Another example of differences in interpretation between social services and health staff was of midwives in a special care baby unit who were suspicious of parents' behaviour. Social workers thought that anxious parents could sometimes seem aggressive or hostile but that this did not necessarily indicate a risk to the child. These differences need to be discussed using all the contextual information available so that a decision can be made about whether and how to act. Both social workers and hospital staff described meetings where such discussions had taken place.

It was agreed by both agencies that in possible cases of neglect or of fabricated illness, it was particularly difficult to reach a consensus. Social workers mentioned other cases where they felt frustrated with medical staff who were not prepared to make a decision about whether a child's injury was accidental or not. Although there are instances where it is not possible to judge either way, social workers said they needed the support of doctors to instigate an investigation.

Some of these paediatricians, they sit on the fence. They don't want to be the one to say, 'yes, that's definitely non-accidental injury'. Sometimes you are dealing with consultants that don't want to be the one that had labelled this family, although we do assessments every day and we have to call the shots on whether something is child protection or whether it isn't and that's what doctors should do. (Area social work team manager)

Conclusions and recommendations

The safeguarding task

Law and policy in relation to children recognise that the assessment of children is multi-dimensional and that the perspective of many practitioners may be needed to build up a complete picture. As the Inquiry into the death of Victoria Climbié demonstrated, hospital and social work staff are particularly key players within this process. To summarise their respective roles:

- Hospital staff must be alert to concerns about a child's welfare and act upon concerns, including referral to children's social services. They should contribute to the assessment and planning process and take responsibility for the safe discharge of the child from hospital

- Children's social services staff must respond to concerns about a child's safety or welfare and co-ordinate an assessment. They must take any necessary immediate protective action and coordinate a plan to safeguard and promote the child's welfare.

This sounds relatively straightforward, and there is a plethora of national and local procedures and flowcharts to support staff. Why then do things go wrong? Returning to the Climbié Inquiry, there were clearly difficulties in the way individual agencies failed Victoria: social work staff had inadequate skills and were unsupported; assumptions were made about 'normal' interaction within African families; the focus was on adult problems rather than the child's needs. The recommendations attempted to rigorously address these failings. Equally importantly, there were difficulties in the way agencies worked together but the recommendations were less clear on the solutions to these.

The Government response was to set out a vision for improving outcomes for all children: *Every Child Matters* and the Children Act 2004 have a strong emphasis on the integration of children's services in order to facilitate communication. However, critics have expressed concern at the exclusion of health from some of these integrated arrangements and it is not obvious how hospitals and children's social services will come together. Even where children's trusts have been established, hospitals are rarely included. Bedfordshire and Hertfordshire SHA have tested new ways of working between midwives, health visitors and social workers around the time of the birth through the 'Who's holding the baby project?' (http://www.bedsandhertswdc.nhs.uk) but such initiatives are scarce.

Project findings

The survey and case studies attempted to explore the working arrangements between hospitals and children's social services and the perceptions of staff working within them about their shared task in safeguarding and promoting the welfare of children in need. The main types of concern about children that arise in hospital settings are:

- unborn babies where there is reason to believe that parents will be unable to provide safe or adequate care;

- children in A&E, outpatient clinics or inpatient wards whose illness/injury may be due to abuse or neglect;

- children with chronic illness whose parents/carers are unable to meet their special needs;

- children who self harm or show other signs of emotional distress.

Key issues

Models for providing a service

The survey revealed different models for the provision of a children's social work service to hospitals, with about half of hospitals having on-site social workers. There was some evidence of attempts to fill the perceived gaps by the funding of specialist posts from voluntary sector or NHS funding. The responsibility for safeguarding children, however, remains with local authority social workers whether they are on or offsite. The presence of social workers on site did seem to facilitate the establishment of effective working relationships in respect of individual children. If managers were also present, there were stronger opportunities to develop joint protocols and to set up liaison meetings. Communication was said to be much easier on a practical level if people were located on the same site: it was easy to find each other, to share recording and IT systems or make time for informal discussion. It was also acknowledged that communication is much easier with people who are familiar.

This is not to say that effective working arrangements cannot be developed where social workers are not on-site. Some settings had worked hard to establish a range of policies and procedures, liaison meetings or posts and audit arrangements in order to improve working relationships. In some cases, individuals had developed ad hoc systems or had taken the initiative to establish a dialogue. It did appear, however, that the task was more complex in these settings and more contingent on personal commitment. Designated and named health professionals, and to some extent liaison health visitors, assumed a particular importance in the absence of on-site social workers.

There is no panacea. Where social workers are based within hospitals, they run the risk of becoming alienated from their own agency whilst not being fully accepted into the hospital. Where social workers are *not* based in the hospital, they may be excluded from decision making altogether and informal discussion may be non-existent and both models present practical difficulties in terms of record keeping and IT systems. Local solutions must be developed.

Expectations between local authorities

Hospital catchment areas and local authority areas are not co-terminous. Children frequently present at hospitals outside their home local authority and the responsibility for the provision of social work support is variable. Where there are social workers on site, they may undertake a limited role with children living in other authorities or they may expect hospital staff to refer them directly to that

authority. Where there are no on-site social workers, the hospital will have no choice but to make this direct contact. Few local authorities appear to have developed and formalised the expectations about the service that will be provided in these circumstances, in spite of it being accepted as a recommendation from the Climbié Inquiry.

Expectations between local authorities and hospitals

This lack of clarity may exist even where children *are* local. Expectations regarding the service to children in hospital are rarely the subject of a formal service level agreement and there is some scope for confusion as a result. On-site social workers may attempt to fill this gap by producing documentation describing their role, or joint protocols may have been developed for a particular service user group, such as pregnant drug users. Some hospital staff remained confused, however, about what they could expect from the social work service and how the service 'worked'.

Threshold criteria

Thresholds for referral to children's social services are a potential source of conflict, particularly where it is unclear whether they are 'child protection' or 'children in need' cases. (In spite of attempts to integrate the approach to such children by adopting the terminology of 'children who are the subject of concern', the language of 'child protection' is still dominant). Thresholds were variously perceived as too high, too inconsistent or too mysterious. There is a risk of referrers 'giving up' if they cannot make sense of the response or, alternatively, inflating concerns to ensure that concerns are taken seriously. Perhaps the difficulty lies in the perception that definitions of child protection are fixed and within the control of social services alone. In reality, thresholds are fluid and need to be continually negotiated.

Status and authority

This notion of negotiated thresholds may not fit comfortably into a medical setting. As various writers have suggested (Gibbons et al 1995; Parton 1998), judgments about significant harm are socially constructed within a 'socio-legal' rather than a 'disease' model. Authority is therefore invested in social workers and the police. This can leave the role and status of doctors unclear: other practitioners rely on the medical opinion about the cause of any suspicious injury but must place this information within a wider context to determine how best to safeguard the child. It is clear that this shared responsibility caused confusion in the case of Victoria Climbié and will continue to cause confusion unless there is good communication. This is reflected in the fact that respondents to the survey expressed contradictory views about where ultimate authority lay.

Effective communication

Many formal opportunities to work together exist at a strategic level and these will be strengthened within the Safeguarding Boards. The level of interaction varies, however, with some areas integrating hospital colleagues into a range of activities whereas others have established discrete health sub-groups.

Of more interest within this project was the operational interface. Murphy (1995) suggests:

> *Some of the most important factors in achieving good multi-disciplinary work do not involve highly technical, complicated issues of inter-agency coordination, but rather are to do with the human issues that staff bring to the child protection process.*

How can the human activity of good communication be supported? In the case of hospital and social services staff, there are a number of factors that make this process complicated. There are different lines of accountability, differences in language, institutional cultures and status. This project suggests that there is no template for achieving good communication but that it requires effort on both sides. This should be proactive through establishing a framework of meetings or simply seeking face to face contact on an informal basis. If communication is purely reactive in response to a crisis, the human relationships and mutual trust needed to communicate may be lacking.

A safeguarding ethos

In this study, we found differences in the importance attributed to joint working: a number of social service departments appeared to have few arrangements in place for dialogue but were satisfied that their relationship with their local hospital was unproblematic. This was at odds with the level of frustration and confusion about social work thresholds expressed by some hospitals, and by the literature on the importance of communication. Similarly, the priority being afforded to safeguarding activity within hospitals was inconsistent. The expectations regarding designated and named health professionals with sufficient status, time and resources was not consistently fulfilled. Where neither social services nor the hospital appeared to be prioritising the interface between them, systems rapidly collapsed. It was clear that a level of personal commitment is important. Equally, there are dangers if child protection is seen as the responsibility of one or two key players so that others can opt out. The promotion of a safeguarding ethos whereby it is seen as everyone's responsibility, however junior or whatever their specialism, is essential.

Access to Child Protection Registers

It was clear from the responses that access to child protection registers by hospital staff is patchy, particularly for children from other local authorities. In the majority of cases, hospital staff had to contact social services to request the information. This is dependent on them having a concern, being able to establish which local authority has responsibility for the child and knowing the contact details for that authority. Gaining information from a register may be particularly difficult out of office hours.

Section 85 assessments

Very few hospitals or local authorities had developed formal arrangements to assess the needs of children in hospital for three months or more. This was both in terms of the hospital having a notification procedure or social services having a robust protocol for assessment. There tended to be an assumption that it was so rare that no special arrangements were necessary or that it would become

known informally through discussion. (The most recent Chief Inspector's report recommended that NHS Hospital Trusts must develop a protocol for this.)

Recommendations

Perhaps the changes brought about since the Inquiry into Victoria's death have created the necessary conditions for effective joint working to flourish but the question remains whether they are sufficient. It is suggested that specific attention needs to be paid to the interface between hospitals and children's social services and that Safeguarding Boards are well-placed to lead this process. It is therefore recommended that:

Safeguarding Boards review the arrangements for providing a children's social work service to hospitals within their area with a view to ensuring that:

1.   The model of service is the most effective to meet the needs of all children using local hospitals in terms of the numbers, skills, location and management of social workers.

2.   There is a formal agreement with other local authorities whose population use hospitals within the area about the way in which a children's social work service will be provided.

3.   There is a formal service level agreement between local authorities and hospitals within their area about the service that will be provided to children in need.

4.   There are robust policies and procedures to support operational practice between hospital and children's social services personnel. This should include consultation, referral, assessment, decision-making, planning and discharge arrangements.

5.   There is a clear communication strategy at strategic and operational level between hospital and children's social services personnel.

6.   Joint monitoring and audit arrangements are established to review quantitative and qualitative data about the safeguarding and promotion of welfare of children attending local hospitals.

7.   Opportunities are provided through joint training or other mechanisms to discuss the thresholds for intervention in order to safeguard and promote the welfare of children attending the hospital/s.

8.   Designated and named professionals are in post in all hospitals and have sufficient status, time and resources to fulfil their role.

9.   A safeguarding ethos exists in local hospitals, to include adult and specialist practitioners, so that all staff understand and are able to fulfil their responsibilities.

10.   Hospital staff have ready access to the information necessary to safeguard children, including relevant child protection register/s, for all children attending the hospital on a 24 hour basis.

11. Hospitals and children's social services have a clear and agreed process for fulfilling their responsibilities under Section 85 of the Children Act 1989 in respect of children in hospital for three months or more.

There also needs to be a wider debate about how hospitals can be included in the move towards integration within children's services.

Appendix 1: Survey methodology

In order to cast some light on the working arrangements between hospitals and social services, national surveys were undertaken. Two survey questionnaires were developed for completion by health and social services staff. The Association of Directors of Social Services supported the project and encouraged Directors to respond. Both questionnaires were administered electronically and sent by e-mail and respondents were asked to submit supporting documents. Respondents interpreted some of the open questions differently and it has therefore not been possible to compare all responses.

Health questionnaire

Questionnaires for health staff were sent to all Children's Leads within Strategic Health Authorities in England with a request that copies be forwarded to all local hospital trusts providing relevant services within their area. Forty-two completed questionnaires were received from hospital trusts. Of these 39 were completed on behalf of the whole trust, two on behalf of one hospital only and one on behalf of the paediatric departments only. Questionnaires were completed by diverse members of trust staff including general and directorate managers, named (n=12) and designated child protection nurses (n=3).

Respondents provided information on 63 different hospitals or units. These included city based teaching hospitals, children's hospitals, local hospitals and small units with some inpatient facilities. These hospitals provided a range of services, including maternity, neo-natal units, A&E, paediatric in-patient and specialist services.

Social services questionnaire

All the 150 local authorities in England formed the sample for this survey. Fifty-one completed questionnaires were received from 49 authorities making a response rate of just under one third. Of the 51 responses, 38 (75 per cent) covered the whole local authority area. Of those 13 (25 per cent) which did not cover a complete authority, five covered services provided in a geographical area within an authority, three covered particular hospitals, four covered some but not all services provided by the local social services department (SSD), and the other was not specified.

Questionnaires were completed by members of social services staff and included service, area and team managers (45 per cent), other managers and directors.

Respondents reported working with 85 hospitals which were based in their local authority areas. These included large teaching hospitals, specialist hospitals - including children's hospitals – and local district hospitals. Of the 51 respondents, 48 (94 per cent) reported having at least one hospital in their geographical area, 23 (45 per cent) had two hospitals and 16 (31 per cent) had three or more. Respondents also had contact with a large number of hospitals

based in neighbouring authorities (or further afield) which provided services to their population. These hospitals also offered a range of specialist services.

Services offered by the 85 hospitals are shown in the table below;

Service provided	Percentage
Maternity	69
Neonatal unit	59
A&E	67
Children's outpatients	79
Children's inpatients	78
Child psychiatry	37
Specialist unit	36

The specialist units included those providing oncology, cardiology, intensive care (both paediatric and neonatal), palliative care, orthopaedics and CAMHS as well as, for example, services for burns and cystic fibrosis.

There was little overlap between responses from social services and health staff meaning that it has not been possible to compare responses at a local level.

References and further reading

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A Shared Responsibility

Safeguarding arrangements between hospitals and children's social services

Jessica Datta and Di Hart

Based on the findings of a Department of Health funded NCB project, this report examines the ways in which hospitals and social service departments work together where children are in need, including a need for protection. The importance of this interface was highlighted by Lord Laming's Inquiry into the death of Victoria Climbié. It is also at the heart of policy initiatives to integrate children's services in order to improve outcomes.

The project included:

- Mapping current working arrangements through national surveys of hospitals and social service departments
- A review of relevant literature, including Part 8 and other inquiries
- Case studies of three hospitals with different models of service delivery, including interviews with key personnel in local agencies responsible for safeguarding children

A Shared Responsibility offers analysis of the project and draws out the important messages about effective working arrangements and practice. The findings suggest that the key to safeguarding children in hospital is good communication, and that there is more to be done if this is to be achieved.