AN EXAMINATION OF COLLABORATIVE WORKING IN CHILD PROTECTION

BY

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DECLARATION

"I certify that this work has not been accepted in substance for any degree, and is not concurrently being submitted for any degree other than that of degree of Doctor of Philosophy being studied at the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised another's work"

Signed by Student: Signed by Supervisor:

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Professionals within the two boroughs who participated within the study and contributed in terms of both their time and professional experience.

ABSTRACT

Background

Collaborative working between health and social care professionals in child protection work has been generally promoted in the western world as best practice (Laming 2009, HM Govt 2010). Problems in achieving effective collaborative working have beset child protection systems and have been a constant feature in a number of serious case reviews (Brandon et al 2010). Collaboration between professionals of different disciplines is complex and involves interpersonal, interprofessional and interorganisational dimensions.

Aim

The aim of this research project was to investigate the extent to which health and social services professionals practising within two health and local authorities perceived that a collaborative approach was adopted between the two agencies when working both with families where there were children in need of services and families where there were children in need of protection. Factors that may enhance or inhibit collaboration were explored.

Method

The sample used was a purposive sample, comprising social workers and health professionals working in one of two boroughs.

A case study approach was adopted and data collection involved a mixed approach of both qualitative and quantitative methods. A postal survey across the two boroughs was undertaken, using a questionnaire which was distributed on two separate occasions to allow comparison of the extent to which there was effective collaboration pre and post the Laming Inquiry. The questionnaire included a series of brief vignettes and a multi staged vignette, based on real life cases which were anonymised and were developed to assess the application of thresholds across the two boroughs and across professional disciplines, and to explore collaboration throughout the safeguarding continuum. The questionnaire used a number of open, closed and scaled questions to generate both quantitative and qualitative data. The

questionnaire was distributed to a total of 311 practitioners at the pre Laming stage and to a total of 300 practitioners post Laming.

Results

In analysing the responses from participants across health and social care, a number of important themes have emerged. The responses to the vignettes demonstrated different levels of professional participation in work both with children in need and at different stages of the process for children in need of protection. Professionals in the borough with established child in need policies valued the multi-agency approach that was adopted in work where there are children in need of services There was lack of consensus in several of the cases in terms of thresholds of concern; a range of factors that may enhance or inhibit collaboration were identified, including shared thresholds, the practice of informal joint meetings, joint assessment and joint training.

The majority of respondents believed the Laming Inquiry had impacted on collaboration in both areas of practice, children in need of services and children in need of protection. Although a number of positive outcomes of the Laming Inquiry were identified, the impact in terms of work load and stress generated as a result of policy change from the Inquiry were highlighted.

In analysing responses in the current study, a theme that was very evident was the extent to which the emotional impact of safeguarding work affects the ability of professionals to achieve a collaborative way of working. In reflecting on the findings of the research the following recommendations are made:

Recommendations

In undertaking this current research and reflecting upon the learning that has taken place, as a result of the valuable input from professionals who participated, the following recommendations are made:

Recommendations at the level of practice

1. Health and social care organisations should consider the development of multi-agency practice teams to provide services for children in need.

2. Health and social care organisations should consider the development of multi-agency safeguarding supervision, based on a model that allows reflection, particularly for complex cases and includes the supportive element for practitioners.

Recommendations at the level of policy

3. Health and social care organisations should undertake assessments at the time of policy change to identify the financial and human requirements to resource the change.

Recommendations for future research

4. Further research is undertaken to explore in greater depth the emotional impact of safeguarding work and potential approaches to support professionals.

5. Future research is undertaken to explore the child and young person's experience of collaborative approaches in safeguarding practice.

CONTENTS

CHAPTER 1
Introduction

1.1 Overview

Collaborative working between health and social services professionals is prominently and persistently featured in a range of government policies and has been widely advocated in the field of child protection. However the extent to which this concept is understood is not clear and the process of translating this from theory and strategy to front line practice raises major challenges and needs closer examination. The current multi-agency systems that are in place, which focus on working together to safeguard children, have served to protect countless children from ongoing harm, but unfortunately these positive examples of practice appear to go unnoticed. In contrast, a number of child protection inquiries have attracted wide media attention and have raised public concern, with frequent reports of professional failings across the key agencies whose roles are pertinent in providing services that contribute to the protection of children and young people. child protection inquiries held following the death of children have, for a number of decades, highlighted similar messages including the need for collaborative working (London Borough of Brent 1985, London Borough of Greenwich 1987, Department of Health and Social Security 1988, Laming 2003, Brandon et al. 2008, Brandon et al. 2009, Ofsted 2010). Policies that have emerged as a result of a number of inquiries have featured a drive towards improving collaborative approaches to working with child protection in recent years (Vincent 2009). However, despite such an approach being seen as mandatory, it has been simultaneously seen as failing to happen (Morrison et al 1990, Hallett 1995, Ofsted 2010).

Such inquiries have frequently highlighted "system failure", which was clearly demonstrated in the report of the findings of the circumstances surrounding the death of Victoria Climbié, where Lord Laming stated:

"I remain amazed that nobody in any of the key agencies had the presence of mind to follow what are relatively straightforward procedures…"

(Laming 2003:4)

The range of child protection inquiries including that led by Lord Laming have increasingly recognised the influence of wider social and ideological changes including the increasing complexity of children's needs and the changing structure and function of agencies with responsibilities that include safeguarding and the provision of services in response to the identified needs of vulnerable children and their families. A number of inquiries have made a series of recommendations proposing a more integrated, corporate approach to concerns about the system that is supposed to safeguard children, identifying the need for improved collaborative working between different professionals. The approach to achieve collaboration is seen to include a common language, shared training, a common approach to information gathering and sharing, collocation of professionals and the implementation of integrated models of team working.

More recent inquiries have recognised that it is not possible for assessment, investigation and safeguarding intervention to be perfected to the extent that they guarantee the safeguarding of all children:

"It is unrealistic to expect that it will ever be possible to eliminate the deliberate harm or death of a child – indeed no system can achieve this"

(Laming, 2003:361)

Laming, although acknowledging the limitations of services and professionals ability to offer a totally fool proof safeguarding service, went on to identify the need for services to be operated more efficiently and effectively. In keeping with the findings of a number of inquiries collaborative working was seen as the route to achieving this. The reality of this happening, in light of the number of professions and organisations involved within safeguarding children practice, resulting in different cultures, policies, procedures, management structures and sources of funding, presents a major challenge and offers the opportunity to explore the theoretical perspective of collaborative working and functioning within the context of whole systems.

1.2 Aims of the research

The current study is a study of local policy and practice before and after a landmark publication (Laming 2003). It is also a study of two boroughs with similar population characteristics but (pre-Laming), different approaches to the provision of services for children in need. The aim of this research project was to investigate the extent to which health and social services professionals practising within two health and local authorities perceived that a collaborative approach was adopted between the two agencies when working both with families where there were children in need of services and families where there were children in need of protection. Factors that may enhance or inhibit collaboration were explored.

1.3 Working definitions

The research was undertaken in two boroughs in Greater London. In the chapters that follow, reference is sometimes made to the United Kingdom as a whole. As this research was undertaken in only one of the countries within the United Kingdom, the variation in terms of both the law, and practice, which serves to safeguard and protect children, needs to be acknowledged. This is discussed in chapter 2.

Throughout the research, there are a number of terms used that are defined within the legislative framework. A child is defined in the Children Act 1989 and 2004 respectively as anyone who has not yet reached their 18th birthday.

The term 'child protection' is now part of the wider concept of safeguarding and promoting welfare and refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. Safeguarding and promoting the welfare of children is defined by HM Government (2010) as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development; and
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

Children in need of services are defined by the Children Act 1989 section 17 and children in need of protection in section 47 of the Act (see Appendix 1).

Abuse is broadly defined in terms of physical, sexual, emotional and neglect (HM Government 2010) (see Appendix 2)

1.4 Rationale for the research study

The rationale for the choice of subject area focused upon the following areas:

- Previous research reports have highlighted the problem of professionals working collaboratively with children in need of protection.
- Recent research highlighted the need for professionals to work collaboratively with children in need of services to prevent them entering the child protection system. It is therefore important to deconstruct collaborative working with children in need of services and children in need of protection and explore this in relation to teamwork.
- There is a paucity of research which considers collaboration across both children in need of services and children in need of protection.
- There is a need to enhance current knowledge of the extent to which collaborative working exists and factors that enhance or inhibit this.
- The analysis of practice across two boroughs enhances the promotion of development in policies and practice.

The rationale for the choice of the two boroughs included:

- Both boroughs were situated in the Greater London area.
- The two boroughs were comparable in terms of deprivation.
- The boroughs had, at the time the research commenced, significantly different rates of child protection registration.
- The boroughs had different policies and procedures for children in need of services and children in need of protection.

Guidance at government level suggests that the child protection system may be envisaged as an individual case career following six sequential stages:

i. Referral and recognition.
ii. Immediate protection and planning the investigation.
iii. Investigation and initial assessment.
iv. Child protection conference and decision making about the need for

v. registration.
vi. Comprehensive assessment and planning.
vii. Implementation, review and, where appropriate, de-registration.
(Department of Health 1991).

Research that has focused on these stages has found that the level of intensity and speed of interagency involvement is not uniform across all stages (Hallett 1995). Research has also tended to focus on the practice of professionals in relation to

their work with children in need of protection as opposed to children in need of services.

In more recent times, there has been a requirement for child protection services to be refocused with a move from taking families through the child protection process to the adoption of a multi agency approach to assessing and providing appropriate services for children in need of services and their families (Department of Health 2000). Refocusing services involves a move away from intervention to prevention and collaborative working between professionals and agencies is seen as paramount in this. Refocusing of the service is considered in more depth in Chapter 2.

1.5 The research design and approach

For the purpose of the study, two London boroughs were selected. The two boroughs were selected specifically because in terms of indicators of affluence/deprivation they were relatively similar (Department of Health 2000a) but at the time the study commenced, had different procedures and practices for child protection. Comparisons of the two boroughs are made in greater depth in Chapter 6.

To achieve the aim of the investigation, a combination of quantitative and qualitative approaches was used. Given the focus of the study it was not appropriate to undertake a hypothesis testing study and therefore the study is an exploratory, descriptive account of professionals' views and experience of collaborative working and the research design adopted is a case study progressing through the following stages:

Stage 1.
A review of the literature to contextualise the broad and complex field under study. The literature reviewed includes the policy context, collaboration and collaboration within the context of whole systems, risk and the assessment of risk and the roles and responsibilities of professionals working within the area of safeguarding children.

Stage 2.

A comparison of the two boroughs was made with particular reference to:

- indicators of deprivation
- child protection and child in need policies, procedures and guidelines
- child protection registration rates and the levels of children in need of services

The purpose of this stage was to consider the extent to which collaborative working may be influenced as a result of local policy or resources.

Stage 3.

The identification and assessment of relevant population samples was undertaken. The sample comprised social workers and health professionals who met the following criteria:

a) They were currently working in the field of general practice, social work, health visiting or school nursing.
b) They were working with/ providing services for families living within one of the two London boroughs.
c) They had had experience within the last 12 months of working with families where there were children either in need of services or in need of protection.

The criteria above were used for identifying the samples for participation in stages 4 and 5. The research commenced in 1999. Stage 4 was undertaken in the period between the end of 2001 and the beginning of 2002 and stage 5 during the period from the end of 2007 to the beginning of 2008. The period of 7 years between the two data gathering stages, 4 and 5, was not intended, but was the result of unavoidable circumstances. However, the extended period of time enabled data to be gathered in the two boroughs, to consider the impact of the Laming Inquiry, which was published in 2003. The extended period, between the two stages, also resulted in the need to make changes to the methods used to gather data in stage 5. The original intention was to undertake interviews with a sample of practitioners who had participated in stage 4, to gather qualitative data. The delay between the two stages meant a number of those practitioners were no longer in post, or had changed roles In addition safeguarding practice had been through significant changes. The timing of the publication of the Laming Inquiry was therefore used as an opportunity to explore its impact on practice.

Stage 4.

Stage 4 consisted of a postal survey across the two boroughs using a questionnaire (Appendix 3). This stage was administered prior to the Laming Inquiry which was published in 2003. The questionnaire was designed to enable comparison to be made in practice with children in need of services and children in need of protection both between different professionals and between boroughs 1 and 2. The questionnaire was distributed to a total of 311 practitioners working in social work, school nursing, general practice or health visiting in either borough 1 or borough 2.

Stage 5.

Stage 5 consisted of a postal survey across the two boroughs using the same questionnaire as stage 4. As this stage took place following the publication of the Laming Inquiry, additional questions were included to explore the impact of the inquiry on practice both when working with children in need and children in need of protection. The questionnaire was distributed to a total of 300 practitioners, working in social work, school nursing, general practice or health visiting in either borough 1 or borough 2.

1.6 Structure of the thesis

In Chapter 2 the literature reviewed detailing the policy context of child protection both historically and currently and at both the local and national level is presented. The recent debate and move towards refocusing of services from child protection to prevention is explored and information is presented to illustrate how, well intentioned policy change, can have an adverse effect in an area that is working well. The policy change can in fact reduce service provision. There have been immense changes throughout the period of the research. These changes are ongoing and so the research will not include any changes initiated after September 2010.

In Chapter 3 the literature reviewed focusing on collaboration is presented.

This chapter explores the concept of collaboration, how collaboration is defined, the relationship of collaboration to the concepts of cooperation and coordination, collaboration as applied to the practice of safeguarding children and factors that

may enhance or present as a barrier to this way of working. Collaboration within the context of whole systems is explored.

In Chapter 4 the literature reviewed exploring concept of risk within the context of multi-agency assessment and its relationship to the application of thresholds and decision making in child protection practice is presented. The process of assessment, risk assessment and risk assessment tools and their use in child protection practice is explored. In focusing upon collaboration the research project clearly identifies that, for collaborative working to be effective, issues such as common language and agreed thresholds are key components. A collaborative approach to the assessment and management of risk underpins the whole concept of safeguarding children.

In Chapter 5 the literature reviewed exploring the concept of professional roles in relation to safeguarding children is presented. Although consideration of the roles of professionals at an operational level is important, it is also important to consider roles at the macro level in terms of central government and the role of inspection bodies. The roles of professionals who were included in the research, social workers, GPs, Health visitors and School Nurses are specifically considered and issues around conflict which may militate against collaborative working are explored. The literature is explored that relates to the issue of stress, experienced by professionals, as a result of practising in this field.

In Chapter 6 the contextual data about the two research sites selected for the study is presented. The study took place in two boroughs, referred to as borough 1 and borough 2 that are part of the Greater London Authority. A range of demographic and socioeconomic data is presented in order to compare the two research sites.

In Chapter 7 the research design and methodological considerations are presented and a detailed account of the process followed for the study is given. The chapter examines the principles and theoretical perspectives underpinning the research design and approach, and considers methodological rigour and ethical considerations. The strategies used for data collection, organisation and analysis are discussed.

In Chapter 8 the findings of the two distinct but linked stages of the study, stages 4 and 5, are described and discussed.

In Chapter 9 the conclusions of the study are presented and the implications for safeguarding practice are identified. The limitations of the study are acknowledged in this chapter and in light of the findings; recommendations are made in terms of embedding learning from the research into practice.

CHAPTER 2
The Policy Context

2.1 Introduction

Stage 1 of the research involved a review of literature. The findings of this review are detailed in this chapter and chapters 3, 4 and 5.

Partnership working and collaboration between health and social services has become a central theme of recent social policy. There is no area in which this is more important than the area of safeguarding vulnerable children. Integrated working and communication within and across agencies that contribute to safeguarding children and young people have been very long standing themes across a range of policies. It does, however need to be recognised that the implementation of policy is not straightforward, and frequently poses challenges to those that are required to translate policy and guidance into practice.

Lipsky (1980) examines what happens at the point where policy is translated into practice, in various human service bureaucracies such as schools, courts and welfare agencies. He argues that, in the end, policy implementation comes down to the people who actually implement it (e.g. teachers, lawyers, social workers). They are the 'street-level bureaucrats', and they exercise a large amount of influence over how public policy is actually carried out. He further identifies a number of pressures that influence the way in which policy is implemented, namely the problem of limited resources, the continuous negotiation that is necessary in order to make it seem like one is meeting targets, and the relations with “non-voluntary” clients. He describes some of the patterns of practice that practitioners adopt in order to cope with these pressures, including different ways of rationing the services, and ways of 'processing' clients in a manageable manner.

This chapter will provide an overview of the policy context in which current safeguarding practice has developed and will consider the influence of the wider policy agenda and that which directly relates to safeguarding children. This chapter will focus on national and local policy, including associated guidance and

reports that have influenced policy development over a period of twenty one years, from 1989 to September 2010. The chapter will also include a brief overview of the policy context leading up to this period. The rationale for the focus being on the period 1989 to 2010 is that this was a period of major development in policy that is directly relevant to the safeguarding of children and includes the Children Act 1989, the Children Act 2004 and the developments that were as a direct result of the serious case review following the death of Peter Connolly in Haringey in August 2007. Throughout the period of the research, there have been immense changes in the development and implementation of policy and guidance. These changes are ongoing; therefore the researcher may make brief reference to, but will not include any in-depth discussion on, any changes initiated after 2010. The policy context at the beginning of the research project up to the distribution of the first postal survey (stage 4), 1999-2001 is summarised in Table 2.1 and the policy context that emerged in the period prior to completion of the distribution of the second postal survey (stage 5), 2008, is summarised in Table 2.2. Although there were a number of other changes to legislation relating to safe recruitment and sexual offence management, the tables focus upon the key safeguarding policy context.

Table 2.1: Summary of key policy context at beginning of the study

Commencement of study	
Policy	**Implications of policy**
The Children Act 1989	This gave every child the right to protection from abuse and exploitation and the right to inquiries to safeguard their welfare. Its central tenet was that children are usually best looked after within their family. The act came into force in England and Wales in 1991 and - with some differences - in Northern Ireland in 1996.
1991 Staff guidance on working together under the Children Act	This document sets out how professionals should work together to safeguard children Updated in 1999.
Framework for the assessment of children in need and their families (DH, 2000)	This provides non-statutory guidance that provides professionals with a systematic framework for identifying children in need and ascertaining the best way of helping those children and their families.

Table 2.2: Summary of key policy context in the period prior to completion of the second survey

Completion of stage 4 of study	
Policy	**Implications of policy**
Keeping children safe report (DfES 2003)	The Government's response to the Victoria Climbié Inquiry report (Laming, 2003) which in turn led to the Children Act 2004.
Every Child Matters green paper (DfES 2003)	'Every Child Matters' was first published as a government Green Paper in 2003. It was launched alongside the formal response to a report by Lord Laming into the death of Victoria Climbié. The original Green Paper sought to build on existing plans to strengthen preventative services by focusing on four key elements: • Increasing the focus on supporting families and carers, the most critical positive influence on children's lives • Ensuring necessary interventions are undertaken before crisis point is reached, so protecting children from 'falling through the net' • Improving accountability • Ensuring professionals receive appropriate training
Children Act 2004	This Act does not replace the Children Act 1989. Instead it sets out the process for integrating services to children so that every child can achieve the five Every Child Matters outcomes: be healthy; stay safe; enjoy and achieve make a positive contribution and achieve economic well-being. It covers England and Wales in separate sections. Besides creating the post of Children's Commissioner for England, the Children Act 2004 places a duty on local authorities to appoint a director of children's services and an elected lead member for children's services, who is ultimately accountable for the delivery of services. It places a duty on local authorities and their partners to co-operate in promoting the wellbeing of children and young people. It puts the new Local Safeguarding Children Boards on a statutory footing (replacing the non-statutory Area Child Protection Committees)

Following completion of stage 5 of the study there continued to be policy changes, some of which are ongoing. Key changes between completion of stage 5 and the end of the study are summarised in Table 2.3.

Table 2.3: Summary of key policy context following completion of second survey to completion of study

Completion of stage 5 to end of study	
Policy	**Implications of policy**
The Apprenticeships, Skills, Children and Learning Act 2009	This Act strengthened Children's Trusts by putting their Boards on a statutory footing, strengthened the challenge function of Safeguarding Children Boards and gave children's centres a specific statutory basis
Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (DCSF, 2010),	Taking account of the recommendations made by Lord Laming in his report, The Protection of Children in England: A Progress Report (March 2009), and other developments in legislation, policy and practice, the Working Together guidance document has been updated and reissued. The document retains its previous format: Part 1, chapters 1 to 8, are issued as statutory guidance; Part 2, chapters 9 to 12, are non-statutory practice guidance.
The Munro Review	Following the election in May 2010 the incoming Conservative/Liberal Democrat coalition government asked Professor Eileen Munro, of the London School of Economics, to review all child protection procedures in England on the basis that previous changes had now made the system too bureaucratic and stifled social worker initiative in making difficult decisions. Professor Munro published her first report analysing the problems in October 2010 and second report in February 2011. The interim reports identified issues around poor IT systems, high caseloads, limited supervision and not enough emphasis on reflective practice and decision making. The final report will be published in April 2011.

This research was undertaken in only one of the countries within the United Kingdom, the variation in terms of both the law, and practice, which serves to safeguard and protect children in different UK countries, needs to be acknowledged. Tables 2.1, 2.2, and 2.3 identify where policy relates to only some UK countries. The Children Act 2004 relates to England and Wales. In Northern Ireland the Northern Ireland Children (Northern Ireland) Order 1995 applies and in Scotland the Scotland Children (Scotland) Act 1995.

2.2 The wider policy context

The division between health and social care has been a key policy issue in England since the foundation of the NHS. Historically, the shift in social policy has resulted in a range of structures requiring different degrees of collaborative working between health and social care organisations in England. The NHS and Community Care Act 1990 resulted in an internal market within health and social services and made it a requirement that 85% of the special transitional grant should be spent in the private or voluntary sector (Henricson 2007). Such plurality of commissioning arrangements resulted in the fragmentation of services due to the competitive contractual framework. The use of numerous providers poses major challenges in terms of effective collaboration, particularly in an area as crucial as safeguarding children.

Following their election victory in 1997 after nearly 18 years in opposition, the Labour government pledged to make a series of policy changes including policies in the areas of health and social care. There was early recognition that the boundary between these two public services was a key issue for service delivery, an issue that prevented the seamless care envisaged by previous community care reforms (Department of Health / Social Services Inspectorate 1991). The acknowledgement that there was a need to break down the health and social care boundaries resulted in developments such as Sure Start programmes, that were seen to play a significant role in contributing to the safeguarding agenda with the changing focus on early intervention. The importance of such approaches both at the level of the child and the tax payer was recognised by Glass (1999:261) who stated that the provision of a comprehensive community-based programme of

early intervention and family support which built on existing services could have positive and persistent effects and lead to significant long-term gain to the exchequer. Such programmes aimed to encourage greater cooperation between health and social services departments and represented a new way of doing things, both in the development of policy and its delivery. This was viewed by Parton (2006) as a serious attempt to put into practice joined-up thinking, together with emphasis on evidence-based policy making.

In 1999 the government published further policy proposals in the document "Partnership in Action". These proposals were subsequently included in the Health Act 1999 and an important section of the Act, Section 31 created an enabling power for health and social care agencies to create partnerships, led by either the NHS or the local authority. Section 31 allowed the exercise of a range of powers that included pooled budgets, lead commissioning and integration of service delivery.

In 2000 the publication of the NHS Plan was a declaration of the government's vision "to redesign the NHS" so that it is built around the needs of patients (Department of Health 2000b). The NHS plan identified "the old divisions between Health and Social Care" as creating obstacles to the planning and delivery of 'seamless' services between the NHS and Social Services departments to meet individual needs. The Social Services departments were required to become directly involved in planning and managing health care provision through the production of health improvement plans, representation on the boards and executive committees of Primary Care Trusts and joint responsibility for delivering national priorities (Department of Health 1997, Department of Health 1998.) A survey published by the Local Government Association (2000) revealed that 71% of local authorities had in place joint commissioning and/or service provision arrangements with the health sector.

Although these changes in service delivery primarily reflected new Labour's "modernisation" agenda, they were also an effective response to the dissatisfaction of service users, who want services which provide continuity of care across organisational boundaries and are accessible through a single entry

point and do not involve duplicated assessment processes or boundary conflicts in terms of responsibility for provision (Fulop and Allen 2000). There is, however, evidence that developing integrated working is challenging and information on the outcomes of such working is complex to interpret and often contradictory (Frost and Robinson 2007).

Despite the overarching picture of a positive move to collaborative working, the majority of these "joined up" arrangements related to adult care services, with relatively few councils considering such approaches for children and young people. This emphasis on adult services is interesting, given the findings of serious case reviews published in the twenty years leading to these reforms which clearly identified, as a key theme, the failure of professionals to work in an integrated way (Department of Health 1991a, Cloke 2000, Brandon et al 2008, Brandon et al 2009). In particular, learning from such reviews identified the failure of services that work predominantly with adults to work in an effective way with those services whose focus is the provision of services for the children of those adults. This clearly demonstrates that, whilst it is challenging for one sector, such as child care, to work in an integrated way, it is even more difficult to achieve this across sectors.

There is some evidence of the integrated approaches apparent at a strategic level being reflected at the level of front line practice for both adult and children's services. The approaches to integration include the development of practice, strategies and frameworks increasingly removing the separate identities and approaches of health and local authorities. The single health and social care assessment and care planning process introduced as a result of the NHS plan, initially for older people who were most vulnerable, was later mirrored in the care of children in need with the introduction of the Framework for the Assessment of Children in Need and their Families (DOH 2000). Nevertheless, the quality of such assessments is dependent on the contribution and cooperation of more than one agency. In reality, the introduction of this multi-agency approach to assessing the needs of vulnerable children and their families resulted in a tendency for some professionals to interpret the idea of social services taking the lead as meaning social workers undertaking single agency assessments. This was further

reinforced by the introduction of national scrutiny of local authority performance indicators. Performance indicators for children's services include the timeliness of completion of initial and core Assessments, and this focus on timeframes can and does militate against social workers involving other agencies in a process that should in fact be a multi-agency approach. The national scrutiny of local authority performance indicators found that a common complaint in relation to specialist services was that, in many instances, assessments were used stringently to ration demand to an unacceptable degree, and consequently the relationship between professional and user was prejudiced (Olsen and Tyers 2004). The issue of thresholds is further explored in chapter 4.

2.3 Child care and protection legislation pre 1989

The balance of child care and protection legislation pre 1989, shifted over time, between an emphasis on removing children from home and keeping them within their family. In the period leading up to 1948 the churches and voluntary organisations provided services that focused on children's welfare. In 1946, the Curtis Report resulted in new legislation in the form of the Children Act 1948, which gave Local authorities an increased role for an extended group of children. The newly emerging children's departments focused on keeping children within their families.

In 1963 the Children and Young Persons Act introduced the duties and powers to "make available such advice, assistance and guidance as may promote the welfare of children by diminishing the need to receive children into or keep them in care." This approach changed as the result of the Children and Young Persons Act 1969, which introduced more compulsory measures for local authorities to take over the parental rights of a child. The 1969 Act brought together the concepts of "care and control", enabling children who committed criminal acts to be made subject of care orders. Further legislation followed in terms of the Children Act 1975 and the Adoption Act 1976. These Acts were in response to concern in the early 1970's about the "drift" of planning for children in voluntary care, and the need for children to be parented in permanent families (Department of Health and Social Security 1987.)

2.4 Safeguarding children and the policy context post 1989

The period from 1989 is significant in that the legislation and guidance that emerged shaped safeguarding practice throughout the period of the research project being undertaken. The Children Act 1989, implemented for the most part on 14 October 1991, brought together legislation on caring for and protecting children and continues to be the key framework for safeguarding children. The Act introduced comprehensive changes to legislation in England and Wales affecting the welfare of children. The Act brought together private and public law into a single framework, which aimed to achieve a better balance between protecting children and enabling parents to challenge state intervention. The Act encouraged partnership between statutory authorities and parents.

The Children Act 1989 is underpinned by a number of principles. The principles include paramountcy, participation, partnership and accountability. The Act clearly states that the child's welfare should always be the paramount consideration and emphasis is placed upon partnership working, both with families and between different agencies and professional groups. Closely linked to partnership is accountability successful partnership will only be achieved if parents and children are made aware of powers and duties and any action that the local authority and other agencies might take.

Within the 1989 Act there are a number of safeguarding provisions. Two of the key provisions are section 17 and section 47. Section 17 places a duty on local authorities to assess and provide services for a child in need if parents wish it and section 47 places a duty on the local authority to investigate if a child is thought to be suffering, or is likely to suffer, significant harm. A theme throughout the Act is that of partnership and collaboration. Section 27 of the Act refers to the duty for agencies to co-operate in safeguarding and promoting the welfare of children.

2.5 From child protection to safeguarding children within a framework of family support

The Children Act 1989 constituted the largest single review and change to child care law in recent history and responded to increasing concerns during the 1980s reflected in a number of public inquiries into child deaths. The Act aimed

to “create an enlightened and practical framework for decision making whether the decision is taken in the family home, in a local authority office, in a health centre or in a court room” (Allen 1998:1).

The Children Act 1989 sought to maintain the importance of the family as the institution for the raising of children whilst acknowledging the need for clear structures for the protection of those children where the idea of the family failed. The Act introduced the concepts of ‘Children in Need’ (Section 17) and ‘Children in Need of Protection’ (Section 47). Whilst this division is helpful, in effect it has helped to create the challenge of thresholds as some families, particularly those where chronic neglect is present, can regularly move across the Section 17/Section 47 continuum. This often results in those families not getting a full service from either.

The Children Act 1989 was implemented in October 1991 and as a result of the Act the child protection legal threshold criterion was introduced, the threshold of significant harm (Section 31: 2). Although a wider legal definition of need was introduced by the Children Act 1989 the duty to provide ‘advice guidance and assistance’ to families was often in practice linked to ‘diminishing the need to remove children into or keep them in care……or to bring children before a juvenile court’ (HMSO 1976).

During the 1990s the government commissioned a series of pieces of research on the functioning of the Children Act 1989. These were published in 1995 in the form of the document: Child Protection Messages from Research (DoH 1995). The research findings revealed that the focus of work in relation to children in need was almost exclusively upon risk and investigation to the exclusion of assessing and providing services to children in need. This tendency to define need in its narrowest sense was noted by Tunstill and Aldgate (2000) in their evaluation of services for children in need. Aldgate (2002) also identified the budgetary implications of identifying needs which results in a requirement to provide services. Aldgate suggests that many local authorities were concerned about the potential financial costs of providing services for children identified as being in need.

Messages from Research (DOH, 1995) effectively challenged the dominant socio-medical model of child abuse. The findings of this series of research, identified a clear need to refocus child protection services, and this led to developments which promoted service delivery that embraced a more holistic understanding of children and their families. In practice this has not been fully achieved as there remains a clear "incident focus" to child protection intervention by social care and the police. This is supported by Brandon et al (2008) in highlighting the "start again syndrome" adopted by professionals as opposed to viewing families holistically.

The debate around the refocusing of child protection services coincided with the new Labour Government and their explicit family policy (Skinner 2003), which focused on supporting and working in partnership with families to reduce child poverty, build stronger communities and reduce crime and progress to more wide ranging policies which focused upon early interventions and parenting (Parton 2006).

The introduction of the Quality Protects Initiative in 1997 and the Framework for the Assessment of Children in Need and Their Families (DoH 2000) firmly located the concept of need within a developmental and ecological framework consistent with the government's broader agenda. The Quality Protects Initiative was in part the government's response to concerns about outcomes for "looked after children" (Department of Health 2002). Quality Protects sought to improve the life chances of young people in the care system and good assessment was seen as lying at the heart of the initiative (Gray 2002).

Since 1997 social policy has used a broader, more strategic vision of mutually reinforcing levels of prevention. Family support is increasingly seen as a means to achieving the overarching social policy goal, the promotion of social competencies and the prevention of social exclusion (Warren 1997). The move towards the model of family support is further demonstrated in the publication of the 'Supporting Families' document (Home Office, 1998) which was an example of the new Labour government seeking to reframe the welfare state as a system that supported people to take responsibility for their lives.

A number of researchers have examined the effectiveness of the family support approach. Thoburn et al (2000) found family support approaches appeared to be effective in the majority of cases of emotional maltreatment and neglect in reducing repeat referrals and Tunstill and Aldgate (2000) found family centres to be effective in families with long-standing relationship problems, where families could opt in and out of services over a long period. Family group conferences appear in a number of evaluations to have positive outcomes for children (Marsh and Crow 1998). The first national inspection of family support services under the Children Act was less positive and noted 'there is little support for front line staff in developing section 17 work and a danger they would collapse under the sheer weight of work' (Department of Health 1996). In contrast, the inspection of services three years on was more positive and quoted 'Almost all families expressed high levels of satisfaction' but went on to note concerns about the relatively low status of family support and unevenness of child protection awareness (Department of Health 1997). However these different findings may in part be as a result of one considering outcomes from a professional perspective with the other considering primarily the views of clients.

For low level concerns, family support may be a way forward in moving the family on from their cycle of abuse or neglect. Nevertheless, for those more deeply ingrained cases the idea of support may conceal the real risks and result in placing the child at further risk of harm as the support is unlikely to be on a long term basis, leading to the abuse recurring once the support is removed.

2.6 Safeguarding children and the policy context following the death of Victoria Climbié

In February 2000 the death of Victoria Climbié resulted in a public inquiry, which was deemed to be the most extensive investigation into child protection systems in British history. After her death Victoria was found to have suffered 128 separate injuries. The Health Secretary appointed Lord Laming to conduct an inquiry into the circumstances leading to and surrounding her death. Phase one of the inquiry looked specifically at the circumstances leading to Victoria's death and heard from 158 witnesses. Phase two assessed the child

protection system in general and consisted of five seminars with oral submissions from 121 expert contributors. The final report was published in January 2003 (Laming 2003).

The publication of Lord Laming's report (Laming 2003) was an important landmark in influencing safeguarding legislation, policy and practice. The report from the Inquiry highlighted the comprehensive failure of coordinated working among the key agencies which have responsibilities for safeguarding children. Since the publication of that inquiry, a whole range of policy and guidance that places emphasis on the need for integration at all levels of Children's Services has been published.

During the period that the Laming Inquiry was in progress there were changes in legislation that were significant but unrelated to the Inquiry. The Adoption and Children Act 2002 replaced the Adoption Act 1976 and updated the Children Act 1989, modernising the existing legal framework for domestic and inter-country adoption in England and Wales. Section 120 of the Act extends the definition of significant harm so that actually witnessing violence can also constitute harm.

The new policy and legislation aims to address four pitfalls of 'organisational individualism' (Huxham and Macdonald 1992), namely, repetition of tasks between agencies; omission of tasks across agencies; lack of common goals and counter-production where the actions of one agency adversely affect the working of another**.**

In 2003 the ensuing Green Paper, Every Child Matters (Department for Education and Skills 2003) included a number of recommendations to improve multi-agency working. Strategic recommendations included those that required the development of Children's Trust type arrangements and the appointment of Directors of Children's Services. Operationally, recommendations included the development of integrated teams of health, education and social services, professionals from a range of backgrounds, to be based in schools and children's centres, implementation of a Common Assessment Framework and information sharing processes and the need to identify a lead professional for children in

contact with more than one specialist service. The implementation of recommendations would in part be assessed by a further recommendation which proposed joint inspection teams with the role of judging services on how well they work together. Every Child Matters set out a new vision of child welfare. It aimed to promote services such that every child is enabled to fulfill their potential.

The Green Paper proposed that services should be developed at an early point and in an integrated way. Although a lot of work has since been undertaken to promote and maintain integrated working it has been difficult to achieve and sustain due to the fact that structural and policy drivers can also act as barriers to the implementation at a practice level, and it fails to take account of the differing governance and cultural arrangements across organisations.

The Green Paper dealt with several policy areas and generated numerous changes. The reconfiguration of children's services created a complex structure that extended and modified existing arrangements. Significantly, the stated aims of these changes went beyond child protection as it is commonly understood, the prevention of physical, sexual, emotional abuse or neglect to encompass the prevention of factors that impact adversely on children considered to be 'socially excluded'. Such factors include ill-health, educational underachievement, truancy, poor living conditions, and engaging in criminal or anti-social activity. As a consequence of this extension of harm, child protection has come to mean the protection of children from failing to achieve their 'potential'. This is a vague notion and raises the question of what might constitute potential and who the best judge of such potential will be. The introduction of the term "safeguarding" has broadened areas of responsibility, particularly for Local Safeguarding Children Boards, and therefore its constituent agencies. In practice the experience of the researcher is that evidence that this broader responsibility has been met in full is not yet available and whether it can be fully achieved with budgetary constraints is questionable.

The Children Act (2004) received Royal Assent on 15th November 2004 and created a Statutory Framework in England and Wales for cooperation between

Local Authorities, key partner agencies and other relevant bodies to improve the well being of children. It places a duty on Local Authorities to make arrangements to promote cooperation and a duty on key partners to cooperate. It also gives the power for all partners to provide resources and establish a pooled fund. There are a number of key sections that relate to collaborative working. Section 10 strengthens the duty to cooperate to promote wellbeing. Section 11 places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of children. The key bodies being local authorities including district councils, the police, the probation service, NHS bodies, Connexions, youth offending teams, governors / directors of trusts and young offenders' institutes, directors of service training centers and British transport police. Section 13 details the creation of Local Safeguarding Children's Boards. Section 17 requires the production of a multi agency Children and Young People Plan. Section 20 creates joint area reviews, which result in the inspection of all agencies providing services to children in one geographical area.

Munro (2004) raises issues of the confusion and a contradiction characterising the Children Act, which, on one hand, aims to safeguard the child, and yet is surrounded by sets of performance indicators and targets which are required to be met to protect organisations. She further highlights the confusion and tensions between blurred priorities to safeguard children whilst continuing to ensure child protection is prioritised. These concerns are also mirrored by Masson (2006) who states, that an analysis of the Children Act 2004 reveals a narrow focus, which ignores key issues and fails to make links between government policy, the law, and local authority action. Three issues exemplify the inquiry's restrictive approach in achieving joined-up services -i) parental responsibility, ii) treating intra-family child abuse as a crime, and iii) local authorities' responsibilities for family support. These three issues demonstrate central government seeking to retain authority without taking responsibility for ensuring the necessary infrastructure and resources are in place to ensure implementation. Despite its success in changing policy, Masson (2006) believes the report from the Laming inquiry is evidence of the inadequacy of such inquiries as a basis for reform at the level of practice.

2.7 Children's Trusts

Children's Trusts were established under Section 10 of the Children Act (2004) which sets out the requirement for agencies to cooperate and promote well being. The expectation was that all areas in England would have a Children's Trust by 2008. Children's Trusts may be virtual rather than actual organisations but the aim is to have a set of effective local arrangements operating at all levels through multi agency governance, integrated strategies – including pooled budgets, planning and commissioning, integrated processing and integrated front line delivery.

In order that these Children's Trusts achieve their intended outcomes, there are a number of challenges to be met, including the need to critically review long standing practice and the need to cut across long established professional and organisational boundaries. These challenges are further compounded by the changing landscape of commissioning arrangements for children's services, including safeguarding. Potentially, such services could be commissioned through Children's Trusts as a multi agency body, through PCTs as 'World Class Commissioners' (Department of Health 2008), or through Practice Based commissioning arrangements (Department of Health 2006.) Research by O'Brien et al (2006) which considered the early findings from Children's Trusts, identifies that arrangements for cooperation in terms of governance and strategic developments are more advanced than for procedural or front line practice. This again raises the issue of how policy can be translated effectively into practice beyond the level of strategy.

2.8 Local Safeguarding Children's Boards

In April 2006 Local Safeguarding Children's Boards replaced Area Child Protection Committees. As well as the responsibility for 'protecting children from maltreatment,' Local Safeguarding Children Boards also have the remit of ensuring children are growing up in circumstances consistent with the provision of safe and effective care and that they should create opportunities to enable children to have optimum life chances such that they can enter adulthood successfully. The Children Act (2004) which defines this extended remit for Local Safeguarding Boards does not clarify what this would look like in practice,

or what evidence would be needed to demonstrate compliance. Additionally, the distinction between the safeguarding function of Local Safeguarding Children Boards and Children's Trusts has not been entirely clear, although this was made more explicit in the revised Working Together document (HM Government 2010.) The role of Local Safeguarding Children's Boards is to ensure the effectiveness of the arrangements made by wider partnership and individual agencies to safeguard and promote the welfare of children. The LSCB therefore has the role of both supporting and challenging the Children's Trust Board in ensuring effective safeguarding arrangements are in place in its area. In many areas the agencies represented on Children's Trust Boards are often the same agencies represented on LSCB's so the extent to which one Board may effectively challenge the other is questionable.

There is an additional challenge for Local safeguarding Children Boards which is the requirement for them to develop the extended role of safeguarding as opposed to the narrow focus of child protection undertaken by the Area Child Protection Committees. The need for Boards to focus on earlier intervention without losing the focus of child protection creates an extensive agenda and in practice is hard to achieve. This was evidenced in the priority review of Local Safeguarding Children Boards (Department for Education and Skills 2008) which found that whilst some safeguarding boards in the review sample were planning significant amounts of work across the three broad areas of activity - preventative, proactive and responsive - the team found that others did not appear to be planning activity beyond their core responsive work for child protection. From 1st April 2008, the work of Safeguarding Boards was again expanded when the child death process was required to be in place. This is a compulsory process and requires all Local Safeguarding Children's Boards to consider all child deaths. This function is set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, in relation to the deaths of any children normally resident in their area and requires Boards to collect and analyse information about each death with a view to identifying any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.

This process offers opportunities for Boards to progress the wider safeguarding function by identifying safeguarding issues that are relevant to their particular area, for example childhood accidents, and work with Children's Trust Boards to plan appropriate preventative strategies, but again introduces the need to focus upon the wider safeguarding agenda whilst at the same time remaining sufficiently focused on their child protection function.

2.9 Common Assessment Framework

The Common Assessment Framework (CAF) is a national standardised approach to conducting an assessment of the needs of a child or young person and deciding how they should be met (HM Government 2006). Practitioners in all agencies have developed it for use so that they can communicate and work more effectively together. Its aim is to support earlier intervention by providing a tool to enable practitioners in universal, as well as targeted, services to assess needs at an early stage and to seek other services to help the child.

The framework was developed following consultation with children and families who said "we only want to tell our story to one person and we don't mind if you share information if we know why you are doing it". The common assessment framework is being developed nationally to help reduce the duplication between agencies and provide an assessment tool used by all practitioners having contact with children and young families. It aims to reduce the time spent in repeated assessments of the same child by different practitioners, encourage multi agency working, provide common language and initiate action where it is needed.

The Children Act 1989 had provided a child in need continuum moving from children in need of services (section 17) through to children in need of protection (section 47). The CAF adds a new dimension: that of children with additional needs.

The concept of thresholds and the dilemma of multi agency differences in interpretation of thresholds, which has major implications for the protection of children and young people, are further considered in chapter 4. The CAF further complicates the application by different agencies when interpreting what they

assess constitutes this new dimension of the continuum, children with additional needs, as the CAF should be an activity that occurs before any social care involvement. This is, by the very nature of the terminology used, intended as a national, consistent approach to assessment. However, in practice many areas are altering the form and adding a local dimension. In some LSCB areas the CAF has been used as a referral form into social care, which has only served to increase the confusion of professionals as to the exact function of the CAF. Teams around the child (TAC) meetings have been developed in some areas as a forum to discuss Child in need type issues where the CAF has been used. Whilst this is a useful initiative, its purpose is sometimes unclear and may produce yet another tier of the complex threshold agenda. Pithouse et al (2009) explore the use of CAF and argue that CAF is not a means of standardising practice but remains to be interpreted differently and draws in other agencies not previously involved in child welfare needs assessment.

2.10 Working Together to Safeguard Children

The 2006 version of Working Together to Safeguard Children (HM Government 2006a), which replaced the 1999 version, was aimed at practitioners and front line managers who have particular responsibilities for safeguarding and promoting the welfare of children. It is divided into two sections, the first being "statutory guidance" which is issued under section 7 of the Local Aauthority Social Services Act 1970. It was intended to provide a national framework within which agencies and professionals at a local level work together to safeguard children. This terminology promoted confusion as to how enforceable it really was. "Guidance" can be defined as the provision of information to advise or direct towards a certain course of action whilst the notion of something being "statutory" means that it is necessary to conform by law. The two terms are contradictory in nature and therefore the publication of the document, rather than supporting practitioners by clearly defining their responsibilities to safeguard children, served to promote confusion, as practitioners across agencies interpreted the term statutory guidance in different ways.

On 1st April 2010 a revised Working Together document replaced the 2006 version (HM Government 2010). The updated version reflects the changes in

policy and practice in safeguarding children since the 2006 version was published. Importantly it reflected findings and recommendations from the 2003 Laming inquiry. The length and complexity of the 2010 Working Together document raises concerns in terms of how easy it is for practitioners to read and apply in practice. The 2010 version increased in length from 256 pages in the 2006 version to 391 pages. The concerns re the length of the document have been expressed by Eileen Munro (Munro 2011) who states that the document is now 55 times longer than it was in 1974 and proposes the separation of the core rules of child protection from professional advice.

The various versions of Working Together to Safeguard Children reiterate the principle of working in an integrated way to safeguard children and young people. However, if there is conflict over whether this can actually be enforced it raises the question as to how effective this principle is in practice.

The underlying principle of integrated working is embedded in current policy, legislation and guidance that focus upon service provision for children and young people. In order to move from rhetoric to reality, shared values and a common language need to be developed to assist effective partnership working to address the needs of children and young people. However, in reality this continues to be difficult to achieve to a full extent, due to competing agendas, differing professional views and continued single agency targets.

2.11 Information sharing and assessment databases

ContactPoint, formerly known as the Information Sharing Index, was a key element of the Every Child Matters programme, aiming to transform children's services by sharing information between professionals working with children, young people and their families in support of more effective prevention and early intervention. Following its launch this data base contained details of 11 million children in the country, along with details of services they had contact with. Section 12 of the Children Act 2004 provides the legislative basis for establishing ContactPoint but its intended implementation date of 2008 was delayed due to growing controversy about the ethics of keeping such confidential mass data. Munro (2004: 180) criticised the proposed system as an effort at the

'state regulation of parenting' that was unlikely to achieve its official aims because of the 'confusion and contradictions' characterising the legislative framework of the Children Act. In May 2010 the government announced the decision to abolish ContactPoint.

Serious case reviews have recurrently identified information sharing as a failure across agencies and the fact that agencies were required to prepare for the introduction of this system, with the need to educate a whole work force and the public, only then to be made aware that it was to be abolished, only serves to create further concerns around when and how to share information. The pattern of the introduction initiatives, following serious child protection cases, and then changing or abolishing them, at a later stage may be viewed as wasting resources that could be used at the level of front line child protection practice. The repeated changes that are policy driven also result in adding stress to practitioners, already working in a highly stressful area of practice.

The Government also identified the need for the implementation of the Integrated Children's System (ICS), a database for collecting child welfare information and for case management for all local authority children's services. Evaluation evidence since its recent introduction has questioned whether it is fit for purpose. Shaw et al (2009), in evaluating ICS, found that inherent problems technically and in inputting data got in the way rather than promoted professional and analytical practice. They conclude that ICS, although seen as a good idea in principle requires drastic simplification.

Communication is a major theme emerging from serious case reviews for more than three decades (Reder et al 1993, Sinclair and Bullock 2002, Laming 2003, Brandon et al 2009) and although ContactPoint was seen by government as a means of addressing this through improved IT, it must be acknowledged that technology is only a tool and still relies on the practitioner who uses the system. Practice needs to go beyond sharing information and needs to ensure information is assessed and analysed. This is evident in the research (Brandon et al, 2008) which found that there was evidence of a lack of ability across agencies to undertake assessments and analyse the findings in order to make robust decisions.

The application of assessment skills increases the chance of practitioners identifying risk factors which serve to increase the likelihood of significant harm. The importance of assessment of risk in multi agency work to safeguard children will be further discussed in chapter 4.

2.12 Joint Area Reviews (JAR)

Joint Area Reviews were another initiative that utilised joined up working as an approach for inspection processes. The joint area review (JAR) was a three year programme which ran until December 2008 with all 150 local authority areas having had one joint area review during that time. A joint area review judged the contribution that the council and its partners in the local area were making to improve outcomes for children and young people. JAR's and Annual Performance Assessments came to an end in December 2008 and were replaced by Comprehensive Area Assessments (CAA), which began on 1st April 2009. The Comprehensive Area assessment focuses on how well local services work together to improve outcomes for local people, and the effectiveness of individual organisations in delivering those outcomes. CAA includes the identification of the strengths and weaknesses in outcomes and services for children and young people.

Joint area reviews gathered evidence during on-site fieldwork investigations into the contributions local services made to improving outcomes for some of the most vulnerable groups of children and young people, and those groups of children and young people who are not doing well enough or who are at risk of underachieving. They also followed up areas of weakness identified in the annual performance assessment. The annual performance assessment process started in 2005 and assessed individual councils' contribution to improving outcomes for children and young people.

The Joint Area Review onsite field work investigations included gathering evidence directly from children, young people, parents and carers, front line workers, senior managers, elected council members and the council's partner agencies. Inspectors also scrutinised a number of randomly selected case files relating to some of the most vulnerable children and young people in that area to

examine how far services worked together to address the specific needs of these children and young people and promote their well-being. While some onsite fieldwork investigations were undertaken in all local areas, joint area reviews were proportionate to risk, so higher performing areas received fewer onsite fieldwork investigations and a smaller inspection team than poorer performing areas which had a greater number of onsite fieldwork investigation and a larger inspection team.

Joint area reviews were normally carried out at the same time as the Audit Commissions corporate assessment of each council. The joint area review was also aligned with the inspection of youth offending teams undertaken by HMI of Probation. An enhanced youth inspection was also carried out at the same time as a joint area review if a local authority's youth service had not been inspected since 2005.

A joint area review resulted in a number of graded and non graded judgments, which were published as part of a report at the end of the joint area review process. This league table culture may be viewed as increasing risks for children and young people as agencies strive to tick inspectors' boxes and target resources at teams of professionals tasked with preparing evidence for inspections at the expense of front line practice. The rationale for changing from one inspection regime to another as is the case with the move from JAR's and Annual Performance Assessments to Comprehensive Area Assessments is not clear. It also remains to be seen as to whether outcomes for children and young people are accurately assessed and the required improvements monitored, as a result of the new inspection regime.

2.13 The Children's Plan

In December 2007 the DCSF published the first ever Children's Plan, which aimed to "to put the needs of families, children and young people at the centre of everything they do." (DCSF 2007.)

It was claimed that the Children's Plan marked the beginning of a new way of working and a very different relationship between government and families – one where at every level there is closer partnership between services and families,

children and young people. The Children's Plan, however, is not based on the five ECM outcomes, but on a new set of strategic objectives. These objectives include a specific objective aimed at safeguarding children and young people. A number of the objectives stated in the plan appear ambitious and difficult to measure, an example being, “achieving world-class standards”, with no consensus as to how world class standards are defined.

It is not clear why the plan did not use the ECM outcomes as a basis, and although the new objectives do not stray far from those outcomes, they are different in emphasis. It also means that there are three different sets of objectives that organisations are working to strategically – the five Every Child Matters outcomes, the six strategic Children’s Plan objectives and the five Public Service Agreement (PSA) objectives; this may result in lack of clarity as to which objectives organisations are working to and may result in some taking priority over others. It also promotes a focus upon developing evidence that meets these objectives, which may result in other aspects of safeguarding, that fall outside the objectives not being given priority.

2.14 Safeguarding children and the policy context following the death of Peter Connolly

Haringey Council, who were criticised heavily over the death of Victoria Climbié in 2000, came under criticism and public scrutiny again over the death of 17-month-old Peter Connolly, in August 2007. At the time of his death Peter was on Haringey Council's child protection register throughout the eight month period of abuse in which he suffered more than 50 injuries. The circumstances surrounding his death led to concerted government action to address a widespread loss of confidence in the child protection system, both in Haringey and more widely. Ministers announced a national child protection review headed by Lord Laming, who led the inquiry into the death of Victoria Climbié. The review would cover a range of areas including current practice in implementing safeguarding procedures, inter-agency working, and key barriers that may impede efficient and effective work with children and families (Laming 2009.)

In addition, Ofsted, the Healthcare Commission and the police inspectorate were requested to conduct an urgent joint area review (JAR) of safeguarding in Haringey. On 1 December 2008, Ed Balls, Secretary of State for Children, Schools and Families, received the JAR (Ofsted, Healthcare Commission, HM Inspectorate of Constabulary 2008) as well as an initial report from Laming on his findings, and on the same day announced his response in a public statement.

He said the JAR had revealed a catalogue of safeguarding failings in Haringey including a failure to identify children at risk of immediate harm, agencies working in isolation from each other, poor sharing of information and insufficient evidence of supervision. Other concerns identified include lack of oversight by senior officers and insufficient challenge by the Local Safeguarding Children Board to its members and also to frontline staff.

On 12 March 2009, Laming delivered his review on child protection, which called for an overhaul of social work training and management and made 58 recommendations for reforms to make children in England safer. Key recommendations included: the establishment of new statutory targets for child protection, the creation of a National Safeguarding Delivery Unit, reporting to ministers, to oversee the delivery of Laming's recommendations and the need for government to ensure that budgets for child protection staffing and training are protected and that there is adequate funding for councils for early intervention and preventive work with children.

The government accepted all of the recommendations. In May 2009, it produced its full response to his review, including an outline as to how all of central Government will work together with local government and front line services, including teachers, teaching assistants, school governors, staff in Children's Centres and early years settings, child care workers and other partners working with children to drive forward reform of child protection services across England. The government response also included details on how the National Safeguarding Delivery Unit would be taken forward alongside a £58m programme to invest in workforce development for children's social workers (HM Government 2009). In June 2010, the government announced the decision to disband the

National Safeguarding Delivery unit with immediate effect and reallocate the resource into new safeguarding priorities, including the Munro review. This is yet another example of the constant change in priorities within the safeguarding arena that practitioners need to be aware of and focus on.

At the same time that the JAR was requested the then health secretary Alan Johnson made a statement on its implications for the health service. He said: "The report highlights clear failures by the local NHS organisations to communicate properly and share information and expertise. These failures are unacceptable." The Healthcare Commission were asked to urgently review whether NHS bodies were applying national child protection standards "as vigorously as they should be". The commission had also agreed to report on the role of the four local NHS trusts involved in the events leading up to the death of Peter.

The Care Quality Commission, which took over the Healthcare Commission's functions in April 2009, published the report on the four trusts in May 2009. This found that failings in the Peter Connolly case had not been fully rectified.
It found that issues that contributed to the failure to protect Peter, including poor communication between staff, under-staffing and the failure of health practitioners to attend child protection conferences, had not been fully overcome in the trusts concerned (CQC 2009).

Following the death of Peter in May 2010 the incoming Conservative/Liberal Democrat coalition government asked Professor Eileen Munro, of the London School of Economics, to review all child protection procedures in England. The Munro Review of child protection: Interim Report, The Child's Journey, the second report of Munro's independent child protection review, was published in February 2011. The Munro Review of child protection: Part One, A System's Analysis, which discussed the problems in the child protection system and how they have arisen, was published in October 2010. The final report will be published in April 2011. The outcome of the review is almost certainly going to result in a number of key changes, both in policy and practice and have implications in terms of resources to effectively implement the required changes, at a time of financial constraints within public services. A key issue that has arisen

in the reviews undertaken since the death of Peter Connolly is the need for child protection to remain in focus and not diluted within the wider safeguarding agenda.

2.15 Policy differences between the two local boroughs under study

As discussed above the period from 1989 has seen a vast amount of activity at a national level to ensure effective systems are in place to safeguard children. The developments in policy at a national level require translation at a local level. The researcher made the decision to include the two boroughs in the research, as the similarities, in their demography and the marked difference in processes for children in need in the early stages of the research, were a key element of the research design. The two boroughs were similar in terms of demography and deprivation indices, and although the child protection polices were unique within each borough, they were both firmly based on Working Together to Safeguard Children (HM Govt. 1999). This similarity of the child protection policy has been a constant similarity throughout the research due to both boroughs progressing to being part of the pan London safeguarding children procedures. However, when this study commenced there were significant differences at the level of local policy in terms of how the two boroughs approached children in need. Whilst one borough concentrated on child protection only, the other had a clear mechanism for approaching children in need from a multi-agency perspective through joint meetings, planning and ring fenced budgets to promote early intervention. This model highlighted the efficiencies of early intervention whilst ensuring an effective response to child protection concerns. This picture has now changed somewhat. The introduction of children centres and the concept of even earlier intervention has left services for children in need diluted. This is an example of how, well intentioned policy change, can have an adverse effect in an area that is working well. The policy change can in fact reduce service provision. The comparison of the two boroughs is further explored in chapter 6.

2.16 Conclusion

It would be difficult to overstate the magnitude of the agenda for change introduced in the UK services since the mid 1990s. Throughout the period the

research study has taken place policy both within the broader context and that which serves to safeguard and protect children has consistently placed emphasis on professional collaboration. Broader policy initiatives focusing upon collaboration include the Children's Plan (DCSF, 2007) which set out the government's plans for the next ten years and aimed to strengthen support for families by placing them at the centre of what were deemed to be excellent and integrated services. This plan also identified the need to shape services that would be responsive to children, young people and families rather than being designed around professional boundaries.

Approaches to safeguarding policy throughout the period of the research project, have fluctuated between a focus upon child protection and the wider agenda of safeguarding children and young people. At the time the study commenced policy was focused on child protection, but following stage 4 of the research there was a move to the wider safeguarding agenda. A developing theme within the policy context has been that of family support. However, despite the ongoing drive to place child abuse in the broader context of family problems, with a response of family support, child deaths continue to arouse widespread concern.

The response to deaths that result in media attention is a drive to reform policy and practice. This is particularly evident in the sheer volume of policy activity following the deaths of both Victoria Climbié and Peter Connolly summarised in tables 2.2 and 2.3. Making the connection between, strategic development concepts and operational activities and processes, on a consistent basis remains a challenge, and often results in placing pressure on a workforce, practicing in an area of high risk. The approach of family support advocated in recent policy proves particularly difficult for frontline practitioners attempting to engage with families. There can be an imbalance in the power relationship between professionals and parents, resulting in the parents becoming the controlling force as the customer or client instead of the child being the client. This can produce fear within the professional network or indeed paralysis of the workforce, which, alongside the pressure that constant policy changes impose upon professionals, results in high levels of stress. This is further explored in chapter 5.

In practice, it appears very ambitious to achieve a range of the policy initiatives without significant additional resources that allow agencies to address the wider safeguarding agenda alongside the child protection agenda. This results in challenge at the level of both the organisation and individual professional, and rather than promote collaboration may result in defensive practice. Parton (2006) raises the point, that because the safeguarding systems are so extensive and definitions ,of concern so broad, with professionals being held publicly to account in times of insufficient resources, an increasing amount of energy and time is taken up by professionals developing and applying a variety of different threshold criteria. Thresholds within the context of multi-agency working are further discussed in chapter 4.

CHAPTER 3
Collaboration Explored

3.1 Introduction

Collaboration has been a key policy priority for more than a decade (Integrated Care Network 2004). Frequently, the implementation of collaborative approaches to service delivery has happened in response to a wide range of service needs, in a broad range of practice areas. The adoption of collaborative approaches is evident in services that include: adult and child and adolescent mental health services, learning disability services and safeguarding adult and children services (Sloper 2004.) Within the field of safeguarding children, the move to collaborative approaches, has been influenced by reports, that evidence, the failure to work in a "joined-up" way, both at the level of policy and practice, resulting in children "falling through the net" (Laming 2003, Percy-Smith 2005). Collaboration, although a useful and motivating concept is extremely complex and often ambiguous, particularly in an area of practice that, in itself, is challenging and poses high risk scenarios. In reviewing the available literature, a number of interrelated terms and definitions are used to describe collaboration. The use of different terminology will be discussed later within the chapter.

The move, from working in individual professional silos to a collaborative approach requires the breaking down of professional hierarchy and professional demarcation (Malin et al 2002). The outcome of this change is the need to develop new ways of working which cross professional boundaries, and require services to be able to respond, in a more flexible way to the increasing complexity of needs in different areas of practice. Within the field of work that aims to safeguard children, Government policy continually requires collaboration at both the strategic and practice level. The rationale for this approach to delivery would seem obvious, in that it aims to promote multidisciplinary practice in order to meet the need of vulnerable children. Better and more efficient services, as experienced by service users, result from improved service co-ordination, information sharing and joint assessment (Sloper 2004).

This chapter will critically examine the literature that explores the concept of collaboration. The review of literature will include how collaboration is defined, the relationship of collaboration to the concepts of cooperation and coordination, whole systems working as an approach to collaboration, collaboration as applied to the practice of safeguarding children and factors that may enhance or present as a barrier to this way of working. The concept of collaboration will be viewed in a broader context than the focus on process, examining its relationship to the meaning it has for the professionals involved, in particular the issues of professional identity and occupational boundaries.

3.2 Defining collaboration

Collaboration in health and social care is a relatively new field of study, with most studies taking place from the 1980's onwards (Roy 2001). It is unclear as to why collaboration as an approach started to catch the attention of academics at this stage, but may in part be due to the advocating of such approaches from inquiries following the death of children. Within the field of safeguarding, the need to adopt collaborative approaches to working, was recognised at an earlier stage than other areas of health and social care, and had been advocated as far back as the report following the death of Maria Colwell in the early 1970's. Collaboration in the field of children in need and children in need of services has continued to be widely advocated as an approach that enables professionals to achieve a cost effective, needs-led, client-focused, seamless service (Griffiths 1988, Leathard 1994), and yet there is a lack of consensus regarding the meaning of collaboration. The lack of clarity regarding definition within organisational or public service literature emphasises the complexities and subtleties surrounding the concept. The term "collaborate" derives from the Latin "com" which translates as "together" and "laborare" which translates as "to work". The literature that defines collaboration tends to fall into two broad categories: the literature that defines collaboration in terms of differing organisational forms and the literature that defines collaboration in terms of process.

The different forms of organisational arrangements, involved in collaboration, include partnerships (Armistead and Pettigrew, 2004; Milewa et al, 2002), alliances (Kale et al, 2001), and networks (McGuire, 2002; Suijs et al, 2005). The

alternative approach is the focus on the generalisable aspects of collaboration as a process or set of processes. An example of this approach is Gray (1989), who takes a rather aspirational stance and defines collaboration as a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible. Huxham and Vangen (2005), have a similar though slightly broader definition, which describes collaboration as people working across organisational boundaries toward some positive end. This definition reflects that of Hornby and Atkins (2000:12) who define collaboration as: "a relationship between two or more people, groups or organisations working together to define and achieve a common purpose." This definition denotes a goal-orientated relationship that may be formed at a range of working levels, including the strategic level (Pettigrew 1992), operational management level (Ovretveit 1994) or at client "face work" level (Hornby and Atkins 2000). In acknowledging the lack of conceptual clarity, much of the literature reviewed focused upon the challenge of collaboration and indeed the barriers.

Throughout the last two decades, there have been a number of initiatives, introduced with the aim of fostering collaborative working. These include, in recent years a range of reports that have emphasised the importance of collaboration in providing optimal care. Indeed, partnership and collaborative working between health and social services has become a central theme of UK social policy (DFES 2003). Holton (2001) draws attention to the establishment of national policy teams with cross cutting remits and the introduction of joint targets for health and social care agencies as evidence of the importance of partnerships to recent policy developments. Dowling et al (2004) expand upon this by stating that partnership is no longer an option, but a requirement.

In reviewing the literature on the subject of collaboration, it became apparent that the term is used to describe a range of arrangements for working together. Terms such as partnership working, joint-working, joined-up working, inter-agency working, multi-agency working, multi-professional working, inter-agency communication, inter and intra-organisational collaboration and collaborative working are often used interchangeably (Percy-Smith 2005).

Siraj-Blatchford and Siraj-Blatchford (2009) discuss the number of different levels and degrees of collaboration that occur in service delivery, ranging from low-level collaboration involving increased communication and co-operation, through to higher levels of collaboration involving co-ordination, coalition and ultimately integration. The approach of viewing collaboration as a continuum from low level to high level, is endorsed by Craig and Courtenay (2004), documented in Table 3.1.

Table 3.1: Collaboration as a continuum (Craig and Courtney 2004)

Low level	Coexistence
	Networking
	Coordination
	Cooperation
	Collaboration
High level	Partnership

Bond et al (1985) developed a taxonomy of collaboration illustrated in Table 3.2.

Table 3.2: The taxonomy of collaboration (Bond et al 1985)

Stages of collaboration	**Definitions**
1.Isolation	Members who never meet, talk or write to one another
2.Encounter	Members who encounter or correspond with others but do not interact meaningfully
3.Communication	Members whose encounters or correspondence include the transference of information
4. Collaboration between two agents	Members who acts on that information sympathetically; participate in patterns of joint working; subscribe to the same general objectives as others on a one –to-one basis in the same organisation
5.Collaboration throughout an organisation	Organisations in which the work of all members is fully integrated

The taxonomy developed by Bond et al is based on the work of Armitage (1983), which was used in the authors' large-scale study of inter-professional collaboration in primary health care organisations in the UK.

Gough et al (1987) support the notion of collaboration existing as a continuum and describe the four levels of: working separately, keeping each other informed, coordinating work and being part of a true team. According to Gough et al., coordination can be seen as an integral component of collaboration. This is supported by a range of authors who describe a range of arrangements for working together which contribute to the complexity of defining the concept of collaboration (Hallett and Birchall 1992, Roaf 2002, Miller and McNicholl 2003). Drawing on the literature from the aforementioned authors, there is general agreement that collaboration exists as a continuum, moving through different levels of endeavour that in totality describe collaboration.

Sloper (2004) provides a different perspective and distinguishes between "interdisciplinary" working and "trans-disciplinary" working. "Interdisciplinary" working refers to a situation in which individual agencies from different agencies separately assess the needs of a child and their family, and then come together to discuss the findings and agree the goals, The term "trans-disciplinary" working is used to classify multi-agency services based on the ways in which the professionals work together at an operational level, alongside the extent of holistic partnership working with families. According to Sloper (2004) "trans-disciplinary" working involves members of different agencies working together jointly, sharing aims, information, tasks and responsibilities.

The common feature of several authors work is that collaborative partnerships exist along a continuum from informal and local collaboration to formal and whole agency collaboration. Ovretveit (1996) identified key dimensions in relation to multidisciplinary teams, the four levels being: Formalisation, Intensity, Reciprocity and Standardisation. Formalisation describes the agreements or contracts that relate to the degree to which agency autonomy is to be ceded in the partnership. Intensity refers to both the range of activities and resources, which

are to be the subject of collaboration. Reciprocity refers to the degree to which equality or power imbalance exists between partners. Standardisation refers to the extent to which the units exchanged are clearly delineated. Miller and McNicholl (2003) acknowledge that collaboration may exist at different levels and distinguishes between levels and degrees of service integration from the level of service users, to staff working together to deliver local services to the highest degree of integration, when whole systems collaborate with regard to the planning, commissioning and management of services.

Evidence from serious case reviews (Brandon et al 2008), clearly demonstrates the gap between the rhetoric and reality of collaboration at the level of practice. Percy-Smith (2005) acknowledges the difficulties in implementing collaboration into practice, and suggests that its development requires careful planning, commitment and enthusiasm on the part of partners, the overcoming of organisational, structural and cultural barriers, and the development of new skills and ways of working. Interestingly this study reflects the views of Gough et al (1987), in that cooperation and coordination are cited as collaborative skills.

In reviewing the literature, the terms "collaboration" and "coordination" are most commonly used as a concept of working together, cooperatively and in harmony and, despite some variation in definitions, in general a collaborative approach in the practice of safeguarding children and young people is seen as beneficial. The approach to collaborative working that views its success as dependent on the skills of professionals is supported by San Martin Rodriguez et al (2005) who suggest that by bringing together in real time the competencies, experience and judgment of a variety of professionals, organisations are trying to respond to a reality that is becoming increasingly complex in terms of both the knowledge and the working methods that are being applied.

In considering a range of literature that considers collaboration, there are two common themes, one that considers collaboration within the context of organisations and their processes and another that considers collaboration within the context of workforce skills. Over time there has been no consistent pattern as to which approach has been more dominant and whether government policy

reflects the dominant literature at that period in time or whether the literature reflects the policy approach.

3.3 Collaboration within the Context of the Conceptual Model of Systems Theory

The practice of safeguarding and protecting children has undergone a number of profound changes in recent years. The reform agenda as described in chapter 2 has had a significant impact on practice. Ayre and Calder (2010) suggest that within the new environment, process and procedures are prioritised over objectives. A similar view is expressed by Butler and Drakeford (2010), who suggest that, targets and indicators are prioritised over values and professional standards. It may be concluded that some of the recurring failures in collaborative working within the safeguarding system, detailed in reports of the findings of serious case reviews, are as a result of practice being undermined by the haste, in which, changes are implemented. This undue haste, results in the failure to fully analyse the challenges of changing a highly complex, multi-agency system. High profile reports that have made a number of recommendations in relation to the need to develop collaborative arrangements to protect children (Laming, 2003, Laming, 2009), give a clear account of what is wrong with current practice, but do not give any depth of explanation as to the reasons. This approach is similar to that adopted when undertaking serious case reviews in England.

Fish et al (2009), present a systems model for organisational learning that can be used within a multi-agency system, by all agencies, to safeguard children. The systems model presented by Fish et al, has been adapted from accident investigation methods used in aviation and engineering, and more recently, in health. Systems theory originated in the natural sciences and is a multidisciplinary way to discover and study systems occurring in nature. The concept of systems theory has also been applied to social and human sciences. Earlier work in this field is that of Senge (1990). Senge applied the concepts of systems theory to human endeavors and organisations and describes systems thinking as a discipline for seeing wholes and as a framework for seeing interrelationships. The goal of a systems approach is not limited to understanding

why a specific situation occurred, but offers the opportunity to study the whole system, learning not only about faults, but what is working well (Vincent 2004).

Fish et al (2009) describe the systems approach, adapted for child welfare work, with the recognition that individuals are not totally free to choose between good and problematic practice, and the standard of practice is influenced by: the tasks performed, the tools available and the environment in which they operate. The whole systems approach, by taking account of the many factors that interact and influence, individual worker's practice, considers the reasons why "particular routines of thought and action take root in multi-agency practice" (Fish et al 2009.)

3.4 Collaboration through whole systems working

The modernisation of public services requires the development of effective partnership approaches, which include all relevant bodies in decision-making processes. The challenge of achieving joined up decision making in part is defining which organisations are relevant ones. To reflect the modernisation agenda, services for children are being planned and developed in different ways from the recent past, based on multi-agency planning, implementation and accountability frameworks. In order to fully embrace the current legislative and policy framework in relation to the safeguarding of children, an ambitious approach has been proposed in the Change for Children document (HM Government, 2004) and Horwath and Morrison (2007); that of whole systems working.

Pratt et al (2000) describe whole systems working as a radical way of thinking about change in complex situations, a combining of theory and practical methods of working across boundaries. They go on to state that whole systems working helps people make organisational connections that enable them to find sustainable local solutions to local concerns. Within the field of safeguarding, the whole model of working from research down to front line practice involves a number of key players and agencies. This is clearly evident in Brandon et al's (2008) publication which provided a biennial analysis of child deaths and serious injuries that resulted in a serious case review. These organisational connections are with

both people and ideas. The word "system" is used to describe the people and the organisations that connect around a shared purpose, rather than a formal organisational structure. Whole systems working results in shifting the focus of attention from parts or individual organisations to the whole, and applies a set of practical working methods to influence the way these individual parts connect and behave towards each other. In applying whole systems approaches to practice Miller and McNicholl (2003) describe a model that distinguishes between levels and degrees of service integration; at the simplest level, the focus is upon collaboration around individual service users. The next level refers to staff working together to deliver local services. The highest level reflects whole systems approaches and occurs when whole systems collaborate with regard to the planning, commissioning, and management of services. Table 3.3 provides a comparison of dimensions that feature in cases of both low-level collaboration and high-level collaboration when a whole systems approach is adopted. It is the higher level of collaboration that government is advocating through Every Child Matters. The dimensions described in Table 3.3 don't take account of the range of professional competencies required to work collaboratively.

Table 3.3: A Comparison of the dimensions of low level and high level collaboration (Miller and McNicholl 2003)

Low Level Collaboration	High Level Collaboration
Limited or no formal agreement	Formal agreements
Agencies remain autonomous	Agencies sacrifice autonomy
Work towards different targets and goals	Work to shared targets and goals
Agency maintains control of resources and funding	Joint responsibility for resources and funding
Staff managed by individual service	Staff managed by partnership
Focus on individual case	Focus on whole service
Decision making responsibility of agency	Joint decision making
Collaboration likely to be voluntary or within guidance	Clear mandate for collaboration at government level
Variable practice dependent on individual	Specific focus of activity outlined in strategic plans
Affiliation to own agency/discipline	Affiliation to partnership
Accountable to agency	Accountable to partnership

3.5 The objectives and benefits of collaborative working

In acknowledging the complexities of achieving collaborative working in practice, it is important to explore the purpose or objectives of developing collaborative approaches and what the benefits, or demonstrable outcomes are, and for whom. At a policy level, the very idea of objectives can be problematic. Hallett and Birchall (1992) suggest that frequently policy objectives are equivocal, multiple and possibly conflicting, as are organisational goals. Within the ranks of the policy implementers, there are likely to be differences of view between various levels of the hierarchy, each bringing diverse ideologies and

interventions. Other perspectives may emerge when service users are consulted, although historically, service user consultation is an aspect that has often failed to take place, and this is even more the case in child safeguarding. Service user consultation in child safeguarding poses the additional challenge of needing to be clear as to who constitutes the service user; the child or their carer. If the approach is to consult with the adult carer, it needs to be acknowledged that the interests of the child may be in conflict with those of adult family members.

Policy that promotes collaborative working needs to be clear in terms of its objectives, and it is important when proposing adoption of collaborative approaches that one distinguishes between objectives in terms of a system that will benefit the client group, objectives that are intended to benefit the service provider, or objectives that are aimed at meeting the needs of funding authorities. Clearly identifying the objectives of such policy may be difficult, particularly with the focus on measurable outcomes. There is very little evidence on how the implementation of policies that promote collaboration is viewed and experienced by users either in general terms of health and social services or in the area of safeguarding. Inherent within the Working Together to Safeguard Children document (DCSF 2010) are a range of objectives, which include: appropriate sharing of information, better coordination among service providers, holistic assessment, comprehensive service provision, improved accountability, improved accessibility, administrative efficiency, improved client participation, and achievement of a holistic approach. Hudson et al (2003), discuss the need for agreement, between the different professional groups involved in collaborative working, to a set of shared objectives. This approach to objective setting makes the assumption that rational planning springs from a conducive environment and will provide the authoritative framework within which coordination will occur at all levels. It also needs to be acknowledged that objectives adopted by practitioners in response to policy directive may be different to those of the organisation, which may include; the achievement of greater efficiency in the use of resources and improved standards of service delivery through the avoidance of duplication and overlap in service provision and the reduction of gaps or discontinuities in services.

These objectives are essentially those of social policy planners, in contrast to collaborative approaches which come from a "bottom up" approach, from professionals engaged in service delivery or, more importantly, from the voices of children and young people as service users. The collaborative approach may do no more than shift from the search for efficiency towards the avoidance of duplication and overlap, which may be viewed as one and the same thing. Collaboration enables a focus to be placed on the need for a range of varied skills of different disciplines in the complex area of practice in child protection.

An emerging theme in the literature on collaborative working is the questioning of the assumption that collaborative working is a good thing, and will result in positive benefits. The identification of demonstrable outcomes is affected by a number of factors, which include: the lack of clarity in defining collaboration, what outcomes are measured and whether they are attributable to collaborative arrangements or a single agency, and the difficulty in separating the impact of collaborative working from other factors.

The last few years have seen an increase in the evaluation of different services, delivered through collaborative arrangements, and on the whole the evidence would suggest that collaborative working does bring about positive change, that leads to increased effectiveness of practice, which are likely to lead to better outcomes. Outcomes that are demonstrated are at different levels: Outcomes for children and families and outcomes for professionals and agencies. Although there remains limited evidence on outcomes of developments associated with collaborative working, the trajectory of evidence is moving in a positive direction.

Evidence in relation to the outcome of collaborative working, for professionals is based largely on professional perceptions. Reported positive outcome include: improved enjoyment of work and well-being, enhanced understanding of the roles of other professionals. There was, however, evidence, in some cases of blurring of roles (Oliver et al 2010).

The use of the CAF has been evaluated and findings show positive outcomes for children and families (Easton et al 2010). Outcomes evidenced, include: Supporting the improvement of the emotional health of children, improved assessment of needs and improved access to appropriate support. These findings reflected those of O'Brien et al (2009), in presenting the evidence of Children's Trust pathfinders. The authors do acknowledge that the extent and nature of the beneficial outcomes identified was limited due to the fact that much of the work was still in the early stages of implementation at the time of the evaluation.

3.6 Collaboration and governance arrangements

Governance can be defined as the combination of processes and structures implemented by the board in order to inform, direct, manage and monitor the activities of the organisation toward the achievement of its objectives (Cern, 2008). The main vehicle for interagency governance in children's services is seen to be through Children's Trusts arrangements, and at a different level, Safeguarding Children Boards which have a role in coordinating and monitoring the extent to which agencies discharge their safeguarding duties.

The concept of interagency governance is challenging, with the bringing together of democratically accountable Local Authorities, Primary Care Trusts and other bodies, e.g. voluntary agencies and private providers, each of whom have substantially different governance frameworks, as well as differences in cultures and priorities.

Hudson (2005) describes three distinct phases of governance in the post-war period, each associated with service refocusing and organisational upheaval. The three phases are referred to as separatism, competition and partnership. Separatism is where each agency and profession plans and delivers its own contribution in isolation from the contribution of others. Competition is where purchasing is separated from providing, and providers are placed in a competitive relationship to one another. Partnership is where agencies and professionals participate in specific and ad hoc collaborative relationships. He goes on to say that, contrary to the rhetoric, the relationship between these phases is not one of displacement but of aggregation, where different modes of governance coexist in

complex and sometimes contradictory ways. This is the case in current public sector governance arrangements where competition and partnership are evident, with the current government promoting a range of providers within one geographical area with different legal constitutions, an example being the rise in social enterprises within the health sector, alongside providers that remain at arms length to the commissioning Primary Care Trust.

3.7 Barriers to collaborative working

Whilst the literature reviewed places a great deal of emphasis on the potential benefits and gains of whole systems working, there are also tensions, conflicts and dilemmas in adopting such an approach. In achieving integration, the independence and identity of individual agencies can be challenged and when insufficient attention is paid to process, partner agencies can become preoccupied by the factors that divide them rather than those that unite them (Hudson 2000, Ehrle et al 2004).

The Audit Commission (2002), in considering the development of integrated ways of working for services for older people, concluded that services that are flexible, well-coordinated, rooted in the view of service users and with strong focus on promoting independence, remain in most areas an aspiration. The findings in relation to older people are very similar to those in safeguarding children, as is evident in numerous serious case reviews (Brandon et al 2008). The Department of Health (2003) concluded in a similar way, stating that for most places a whole systems approach is a statement of aspiration rather than a statement of achievement. It identified a number of barriers, including the challenge of gathering service users' views coherently and comprehensively across organisations, different parts of organisations contributing to different whole systems, the budgetary pressures resulting in organisations reverting to unilateral action and failure in cooperation when an organisation does not see itself as a partner within a whole system. Where whole systems working, including service user participation, has been successful, there has been commitment to rising to the challenge of change and being inclusive of all stakeholders, for example, in the development of expert patients schemes, where organisations have really listened to the perceptions, ideas and experiences of

those going through the disease. The different levels of participation among agencies may be the result of power imbalances, where partnership working is dominated by the agenda of a particularly powerful or forceful agency representative (Billis and Harris 1996). The implication of this is that whole systems initiatives need to resolve a range of issues if participants are to be clear, committed and possess capacity to participate effectively.

Lok et al (2005) investigated the relationship between perceptions of organisational culture, organisational subculture, leadership style, and commitment. The researchers found that the perceived organisational subculture has a strong relationship with commitment. Furthermore, the results identified the benefits of innovative and supportive subcultures which had a positive relationship to organisational commitment in comparison to a bureaucratic subculture. Elements of a supportive culture are further explored in chapter 5, within the context of the effects of professional stress in adopting collaborative approaches to safeguarding children work.

3.8 Professional identity and occupational boundaries in the context of collaborative working

The process of reviewing the literature in the area of collaborative working and whole systems approaches to achieving this has highlighted the concepts of collaboration and their implications for the formal structures of health and social care services. The literature does however seem to have paid insufficient attention to the area of relationships and the way that the adoption of collaborative working approaches forces professionals to reconsider their relationships with other occupational groups. In reviewing the social psychology and organisational literature, one prominent theory that addresses inter-group relationships is social identity theory (SIT). This approach has been applied to a number of social issues and organisational studies and is useful in enhancing professional understanding of the relational difficulties encountered between health and social workers in working together to safeguard children. This theory draws upon the work of Tafjel and Turner, (1986) and Turner, (1991). An important element of this approach is, according to Hogg and Abrams (1999), the individual's focus on how they classify, identify and compare themselves with particular social groups. An

outcome of this process is that the individual identifies and accentuates group differences, which often results in forming stereotypical descriptions of other groups and favourable impressions of their own group. This process can result in relationships where conflict is a constant feature. Social identity groups can be defined as groups in which an individual's self-concept is derived from membership of the group, along with the psychological value and emotional significance attached to that membership (Booysen 2007:25).

Some researchers have suggested strategies that may prevent conflict and therefore enhance successful collaborative working, including the organisation of aspects of service in a way that increases contact between the groups (Hudson 1998). In the field of safeguarding children, joint visits between health and social care professionals and multi-agency learning sets may contribute to reducing professional conflict by enhancing understanding of each other's roles. The application of learning from this theory also has the potential to enhance relationships generally between differing professional groups. Professional roles in the context of collaboration are explored in more depth in chapter 5.

3.9 Collaboration in practice

The transference of the principles of collaboration from paper to practice has presented major challenges. The problems of improving and co-ordinating services have been approached in many different ways and at various levels including joint planning, restructuring of services, joint projects, joint procedures and joint funding. More general research on multi-agency working also provides consistent findings on factors that can facilitate or act as barriers to coordination of services (Watson et al 2002, Cameron and Lart 2003, Sloper 2004). At an organisational level, key factors facilitating joint working have been found in the planning, implementation and ongoing management of multi-agency services.

In planning the services, the studies reviewed suggest successful multi-agency working is promoted by a number of factors. Clear and realistic aims and objectives are deemed to be essential and there is a need for these to be understood and accepted by all agencies, leading to a clearly defined model of how the multi-agency service will operate. There also needs to be agreement about how resources will be pooled or shared. Roles and responsibilities need to

be clearly defined so everyone knows what is expected of them and others with clear lines of responsibility and accountability. There needs to be commitment of both senior and frontline staff, which is aided by the involvement of frontline staff in the development of policies. Strong leadership and a multi-agency steering or management group need to be present to ensure an agreed timetable for the implementation of changes and an incremental approach to change. There needs to be a process of linking projects into other planning and decision making processes. Another important feature is good systems of communication at all levels, with adequate IT systems. The other factor that is often overlooked is the involvement of service users in the development and evaluation of the services, although this is complex to achieve within the context of governance and ethical approval arrangements.

In implementing and managing the services, the studies reviewed as part of this research project, identified a number of requirements. Shared and adequate resources including administrative support and protected time for staff to undertake joint working activities were seen as essential. Recruitment of staff with the right experience, knowledge and approach was also viewed as important. Joint training, team building and "time out" to take part in those activities are further requirements (Roaf 2002, Milbourne et al 2003). Staff need to be supported and offered supervision. This will be further explored in chapter 5. The monitoring and evaluation of services, with policies and procedures being reviewed regularly in the light of changing circumstances and new knowledge, is essential.

Hunter and Wistow (1991) examine the experience of collaborative working in the care of older people and suggested that a more comprehensive examination of joint activity reveals a mixed pattern of failure and relative success. They further suggested the need to make a distinction between at least three levels of joint activity, joint planning, joint management and joint working or joint service delivery. Although this study is dated, it is still relevant and, despite progress in developing joint working in some areas of practice, there continue to be difficulties due to different funding streams as well as conflicting agency cultures. This was highlighted by San Martin Rodriguez et al (2005) who discussed a range of

cultural factors including the elements of understanding, respecting and valuing the roles of other professionals.

From reviewing a wide range of literature as part of this study, it is evident that whether or not the corporate rationale or "top down" approach is adopted, (Meads and Ashcroft 2005), those advocating collaborative working in child protection on the basis of experience in practice, stress its functional purposes and consequences in terms of benefits for service users and service providers (Horwath and Morrison 2007).

There are, however some writers who challenge the orthodox mass and draw attention to the potential for collaborative approaches to achieve a greater degree of social control (Westrin 1987). This challenge could equally be applied to the 2004 Children Act. Although the need for collaborative working is inherent within the Act, it is, in fact, an extraordinary piece of legislation, containing two important sections that have significant implications for civil liberties and authors such as Westrin (1987) may argue that the Act has taken the concept of collaboration too far. Section 12 of the 2004 Act facilitates the establishment of electronic data-bases to track the progress of all children in England and Wales. Section 10(2) of the Act specifies five areas that are subject to surveillance in the interests of the child's welfare, including, the contribution made by the child to society. This specification is offered in the context of conferring significant power on professionals that come into contact with a child, through the adoption of a new legal category of 'concern' as the criterion for information-gathering and possible intervention. The far-reaching sweep of these proposals, allied to the electronic tracking system, was the reason for the alarm that was expressed as the original Bill was examined in its passage through Parliament leading to the Children Act receiving Royal Assent on the 15th November 2004. Although these views, which arose from cross national comparative analysis studies, raise questions about the dominant rationalising paradigm which has accompanied the persistent search for a greater degree of collaboration between health and social care, the dominant view in the literature supports a collaborative approach as a necessary and valued approach albeit fraught with difficulties and challenging to achieve.

In searching the literature that has addressed outcomes of collaboration it was apparent that appraising the outcomes is impaired both by the limitations of existing research studies and additionally by the inherent problem in studying outcomes in social welfare, since they may not be evident and thus measurable in the short term. Fuller (1989) identified other difficulties, in that there is a need to establish and identify the outcomes, to trace and measure postulated effects at various levels and to establish that they are indeed consequences of the policies and practices under review. This is particularly difficult in the current climate of constant shifts in agency structures and functions. It is therefore difficult to establish causal links between collaboration as an input and particular identified outcomes. It is also difficult to assess the input in terms of whether real collaboration is taking place. Westrin (1987) suggests the need to consider immediate, intermediate and ultimate goals or outcomes. Many research studies on collaboration have tended to focus on process rather than outcomes, in particular looking at the dynamics of working together rather than the effectiveness in terms of quality of services provided.

Where researchers have considered outcomes, these can be categorised in terms of outcomes for service users and outcomes for the service delivery system. In reviewing the available literature, both positive and negative outcomes have been identified.

3.10 Collaboration and whole systems working in services for children

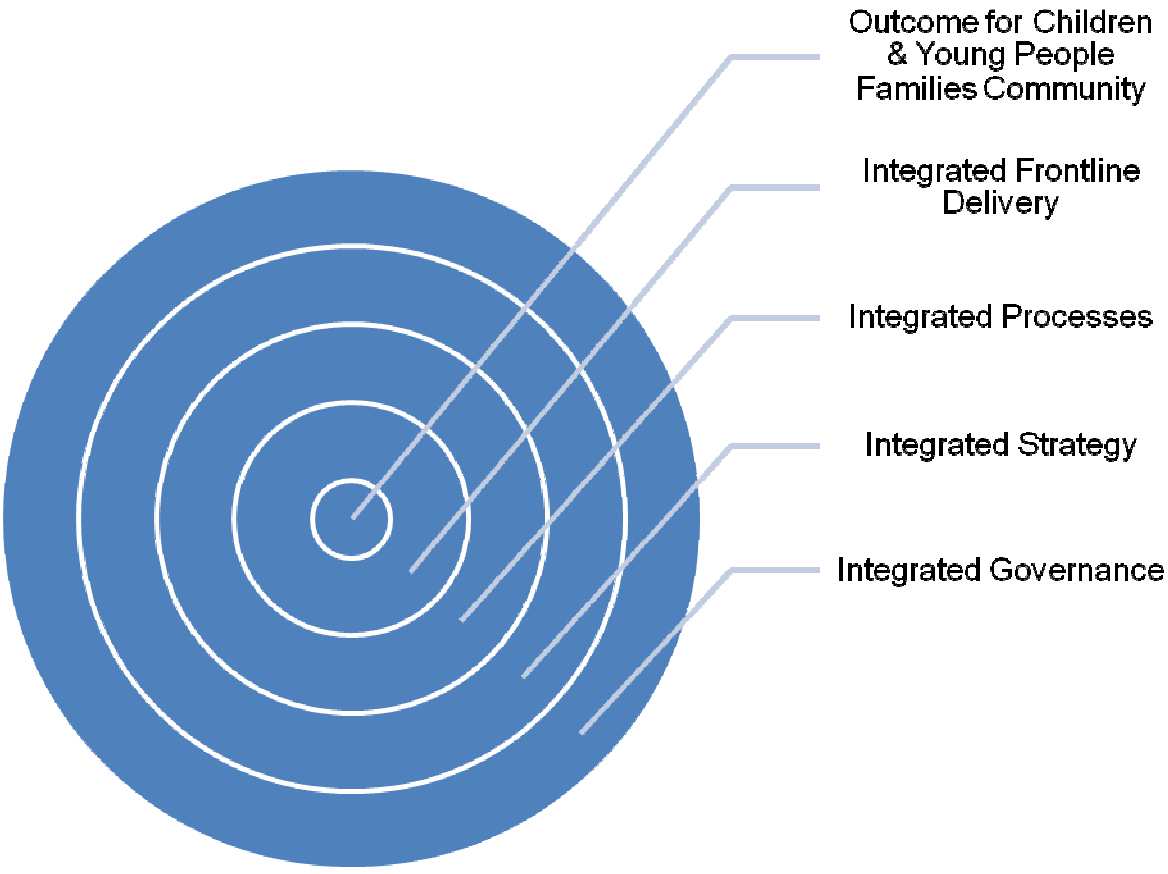
Increasingly the government is recognising the interconnected nature of child welfare issues, with the interface between different agency commissioning arrangements and the wide range of providers and services that focus on children interfacing with those that focus on adults. An example of this is service provision for families with children where the parents misuse substances. Services are often commissioned by PCT's, County Councils and possibly through Practice based commissioning clusters. Services may be provided by a range of providers including different health Trusts, social care providers, and the third sector. There is increasing recognition at government level that the response to these complexities is integration of localised services, adopting whole systems approaches (Milbourne et al 2003). Whole systems working as a solution to the

delivery of Children's Services was proposed in the Green Paper, Every Child Matters (Department for Education and skills 2003) where it was noted that children's needs are complex and rarely fit neatly within one set of organisational boundaries, with the categories around which services are organised overlapping, being fluid and at times blurred. This approach to planning and delivery of services is supported as a way of promoting better outcomes for children. This whole systems approach reflects formal collaborative approaches adopted in the United States of America for more than a decade (Ehrle et al 2004). It needs to be acknowledged that approaches adopted in the United States of America, due to different socio economic factors and health and social care systems, may not be effective if adopted in the UK. It is also important to note that in implementing Children's Trust type arrangements unless the purpose of such arrangements are clearly defined there is a danger that such arrangements will not result in improved outcomes for children and young people. This point is clearly illustrated in the report Are We There Yet? (Audit Commission 2008). The report is the first independent analysis of the new arrangements. The report highlighted confusion over the multi-agency bodies, reporting that they in fact frequently "get in the way" of service delivery and went on to state that in most areas there had been no impact on improving outcomes because "there is little experience or knowledge of joint commissioning". In summary, the commission's verdict was that the government had been too prescriptive in its bid to introduce new ways of working.

Dyson et al (1998) found that the quality of collaborative working within the multi-agency context, such as the approach used to safeguard children, is influenced to a high degree by the intra-agency environment of each constituent agency. The more turbulent, poorly led and poorly resourced, the agency the greater the challenge in achieving whole systems working. This is further hindered in agencies that have exhibited a history of conflict (Roaf 2002, Ehrle et al. 2004). The findings of serious case reviews have constantly revealed the interplay between the structural issues within individual agencies (DCSF 2008), however learning from such reviews has been difficult to embed into practice, yet may lay firmer foundations for the adoption of whole systems working.

The rational whole systems approach advocated by government is demonstrated in the Change for Children document (HM Government 2004) where it is depicted as the "Onion model" (figure 3.1). This model is developed with a number of the characteristics suggested by Miller and McNicholl (2003) being an integral part. The characteristics suggested include a child and family centred approach, improved access and advice, enhanced mainstream services, co-location and integration of services, a move towards organisational integration and whole systems working.

Figure 3.1: The onion model of policy implementation (HM Government 2004)



The onion model is produced as a way in which it is expected a local Children's Trust will operate. The model places outcomes for the child or young person in the centre, considering them within the context of their family and their community. The outer layers contributing to the achievement of those outcomes consist of integrated processes, frontline delivery, strategy and governance. As part of the change for children programme, integrated processes include the Common Assessment Framework discussed in chapter 2, shared referral, lead professional arrangements and multi-agency information sharing. Initiatives that contribute to the achievement of frontline delivery include services delivered through children's centres, extended schools, a common core of skills and multi-disciplinary team working. Examples of integrated strategy include needs analysis, Children's plans, local workforce planning, joint commissioning and pooled budgets. Integrated governance is achieved through the work of Children and Young Peoples Trust Boards and safeguarding Children Boards.

In allowing local variation in developing integrated ways of working, the issue of central Government coordination is overlooked. The concept of a Children's Trust is underpinned by the Children Act 2004 specifying the duty of agencies to cooperate in focusing on improving outcomes for all children and young people by bringing together services. The way such changes are planned and implemented needs careful consideration in light of the findings by the Audit Commission (2008).

The main recent integrated innovation at the strategic level is the statutory appointment of a Director of Children's Services as well as a Lead Member, who is a local councilor. The responsibility of the Director of Children's Services includes making arrangements to secure cooperation and to be a clear channel of accountability. The Lead Member's responsibility includes playing a key part in developing effective joint leadership and clear local accountability arrangements (DCSF 2009). Managerially, Children's Services as a collaborative structural arrangement have evolved and consist of the integrated services of education and the social care function of the local authority. It therefore remains unclear how other key stakeholders will be held to account through this position and the Director may be in the position of having responsibility without the power.

There is a requirement for a multi-agency children and young people's plan to be produced. These plans have similar difficulties in holding key stakeholders to account. There is the danger of them developing in the same way as children's services plans developed as stand alone documents, bearing little resemblance to policy formulation and service delivery across a locality (Hudson 1997). This is due to a tendency for the process to be a paper exercise to satisfy government scrutiny characterised by a failure to engage front line practitioners and service users.

Change for Children (HM Government 2004) states that "better outcomes will be secured by services working together more effectively on the front line……The duty to cooperate……..operates not just at the strategic level but also at the front line……arrangements need to involve among others, schools, GPs, culture, sports and play organisations and the voluntary end of the community sector" (3.1, 3.2). What the publication fails to address is how this will be translated to practice, a particular challenge when success relies on arrangements that include a range of individuals and organisations, including independent contractors such as GP's. This aspect is discussed further in chapter 5.

There are a number of key integrated processes that link to front line delivery of the Whole Systems way of working. These processes include Common Assessment Framework (CAF) and Information Sharing. The Common Assessment Framework aims to provide a uniform approach to the assessment of children and young people with additional needs, which can be built up over time and, with consent, be shared between practitioners. In parallel, local partners should be working to improve practice in the sharing of information between practitioners and agencies with trailblazers, such as Sheffield, piloting such arrangements (Cleaver et al 2004). Despite the process of piloting arrangements, the implementation of arrangements on a national level have been slow to proceed, which may be an indication of the complex nature of integrating processes across agencies.

In addition to assessment and information sharing, a number of components have been identified to contribute to achieving effective whole systems working at the

frontline. These include services delivered through co-located multidisciplinary teams based in services that include Extended Schools and Children's Centres with individual case coordination through a lead professional. There have been a number of authors that have identified the challenge in developing effective whole system working and the need to fully engage frontline practitioners. The Change Agent Team (Department of Health 2003) recognised that the whole system was not simply a collection of organisations which need to work together but a mix of different people, professions, services and buildings which have patients and users as their unifying concern and deliver a range of services in a variety of settings to provide "the right care, in the right place at the right time".

Providing a similar view, the Audit Commission (2002) suggested that a successful whole system requires three key elements that encompass: firstly, a shared vision rooted in the views of service users; secondly, a comprehensive range of services delivered by flexible, multi-professional teams; and, lastly, a way of guiding service users through the system to make sure they receive what they need, when they need it.

3.11 Moving towards whole systems working to safeguarding children

The concept of the whole system has become one of the key elements of planning in health and social care and the idea that the whole system needs to be addressed is widely recognised. However the models used for understanding the systemic nature of organisations and networks often appear to be more like a series of sound bites than a coherent theoretical framework, developed through robust leadership. There is frequently evidence of marked gaps between the theoretical rhetoric and safeguarding practice as was found by the Audit Commission (2008). Approaching the complex behaviour of systems without properly understanding the theoretical basis for actions will lead to frustration and in some cases harm.

In practice, the concept of the whole system is not used in any coherent manner. It is used mainly in considering complex social problems such as child abuse that run across the boundaries of organisations or agencies. This highlights a need to

ensure that responses to the needs of children and young people in need are planned and co-ordinated between the agencies involved and hence become a more meaningful focus for a whole-systems approach.

The attempted solutions to these problems have tended to focus on better co-ordination of services and attempts to set up structures between the different agencies, such as joint planning, pooled budgets, single assessment processes, co-location of staff and joint teams. These attempts to reduce barriers between organisations are not based on systemic analysis but on the command-and-control approach of successive governments, such as Joint Area Reviews as discussed in chapter 2.

The use of the whole system idea does not necessarily lead to a careful systemic analysis but to responses based on common-sense resulting in linear approaches. It has been long recognised in systems thinking (Senge, 1990) that the behaviour of complex systems is counter-intuitive and common-sense actions often make things worse rather than better. However, given the fact that child safeguarding is highly politicised, perhaps practitioners could not risk being counter-intuitive. In looking at the area of safeguarding children, the solutions have focused on a common-sense idea that the effects of boundaries can be reduced or changed by mechanisms such as joint planning and joint assessment. In adopting this narrow focus, key elements at the level of the individual, including the significance of professional identity and occupational boundaries, need acknowledgement. As attempts based on joint planning and assessment have failed, an increased focus on reducing boundaries and producing a whole system through proposals for multi-disciplinary structures such as children's trusts has been evident. The view that poor communication is best tackled through structural changes aimed at reducing boundaries between organisations has been a constant feature. An alternative view, based on a Marxist perspective, is that child abuse can only be prevented by increasing state intervention into the private domain of family life (Dingwall et al, 1983). This approach is also seen in current Conservative family policy and is discussed in further depth in chapter 2.

3.12 Embedding collaborative working in the practice of safeguarding children

In the field of child protection the methodological difficulties in evaluating research and the limitations of the knowledge base pose difficulties in analysing outcomes. Evaluation of collaborative working in the practice of safeguarding is in the early stages, but evidence to date shows some positive outcomes as discussed earlier in this chapter. Evaluation of outcomes is made complex due to the fact that even when there are clear outcome measures used, frequently there is no control group A range of studies promote the benefits of collaborative working within safeguarding children practice (Totah and Wilson-Coker 1985, Mouzakitis and Goldstein 1985) and the promotion of such an approach is advocated by the Working Together to Safeguard Children document (DCSF 2010). A number of studies that look at outcomes were undertaken in North America; however, there are some British studies that consider the working of the child protection system, an important prerequisite to evaluation (Dingwall et al 1983, Corby 1987, Hallett 1995).

Integrated working is inherent within the Children Act 2004, which is concerned with the achievement of five broad outcomes: health, safety, economic well-being, achievement and enjoyment and contribution to society. Axford and Berry (2005), in recognising the importance of adopting a multi-agency approach, set out strategies to help senior local policy makers, managers and practitioners in children's services measure outcomes in a multidisciplinary context. They refer to the importance of using population assessments of need to provide critical information for making hard decisions about resource allocation and in helping shape the nature of services to be provided. The authors further state that the assessments of need can then provide baseline data against which to assess service effectiveness. In using the needs assessments to measure outcomes Axford and Berry (2005) list nine features and state that although it is not important that needs assessments evidence all nine, a number of them should be evident. The nine features listed by the authors include evidence of a multi-dimensional perspective of need, a focus on outcomes rather than outputs, the need for objective threshold criteria and the use of measures that have proven reliability and validity.

The literature reviewed as part of this study that considers the benefits of collaborative working reveal more positives than negatives, although it needs to be acknowledged that this can be subjective. Where positive outcomes are evidenced, it is important to consider learning from research as to how collaboration can be facilitated.

The Government paper Partnerships in Action (DH 1998) offered proposals as to how health and social services bodies could work together. These include possibilities for pooled budgets and plans for a more effective cross-over in providing services across health and social care. The approach is a move away from the focus on organisational structures and boundaries to an emphasis on individuals and groups. This requires a duty of partnership to operate in a way that goes beyond a narrow view of the functions of the organisation and recognition that collaboration can only be established where there is trust and confidence in partners. The development of collaborative working will undoubtedly require changing the culture of insular working and differing values amongst health and social care professionals at all levels within organisations.

Historically the emphasis on collaborative working between health and social services professions in their work with families with children in need of protection can be traced back to the early seventies. The report into the death of Maria Colwell (Department of Health and Social Security, 1974) highlighted the failure of professionals to work together effectively, concluding that the greatest and most obvious failure of the system was the lack of, or ineffectiveness of, communication and liaison. This problem has continued to be found in subsequent child death inquiries and indeed in the inquiry into the death of Victoria Climbie, those same failures were glaringly apparent (Laming 2003) and more recently following the death of baby Peter in 2007. Walton (1993) argues that the dominant assumption of these reports, and the wider public debate, was that the problems were due to poor cooperation between professionals and agencies, with the solution being seen in the form of the development of better procedures and systems for interagency working. The outcome of this approach is the evolution of a child protection system marked by a concern with formal structures and procedural correctness at the expense of attention to the processes

of interagency relationships. The child protection system is thus operated through three key central components; Safeguarding Boards (previously the Area Child Protection Committees), the child protection conference and the child protection register (now the child protection plan).

Following the death of Victoria Climbié and the subsequent inquiry (Laming 2003), the ensuing Green paper, Every Child Matters (DfES 2003) included a number of recommendations to improve multi-agency working. The recommendations include the establishment of Children's Trust arrangements, integrated teams of health, education and social services professionals, co-located in schools and children's centres, a common assessment framework and information sharing systems, the introduction of a system of lead professionals, and joint inspection teams judging services on how well they work together. The Children Act 2004 creates a statutory framework in England and Wales for cooperation between local authorities, key partner agencies and other relevant bodies to improve the wellbeing of children. It places a duty on local authorities to make arrangements to promote cooperation and a duty on key partners to cooperate. It also gives the power for all partners to provide resources and establish pooled budgets.

In England, the National Service Framework for children, young people and maternity services (DOH/ DFES 2004) also reinforces the notion of a coordinated approach to the provision and delivery of services for all children. Standard 3 of the Framework proposes that children, young people and families should receive high quality services, which are coordinated around their individual and family needs and take account of their views. Although this concept of user involvement appears to be one that is a given right, in practice there is frequently little evidence of it and there is a tendency towards being resource-driven as opposed to needs-led (Baginsky 2007).

The importance of collaborative working in safeguarding children is not particularly new and has been reflected in the literature proposing shared learning. Within safeguarding, most Safeguarding Boards have developed multi-agency safeguarding children training strategies and deliver a range of multi-

agency safeguarding children training courses. Carpenter et al (2009) undertook a study that looked at multi-agency training delivered by eight Children's Safeguarding Boards. One of the key findings of the research was the value that participants placed on the opportunity to learn together and the substantial and significant gain in knowledge as a result of such training. The knowledge gained included knowledge about how other agencies and professionals function as well as what their responsibilities might be.

3.13 The challenges of collaborative working to safeguard children

Although in some areas collaborative working has been demonstrated as being effective, which can be evidenced in areas where health professionals are placed in assessment teams, in others, there are repeated examples of failure to work collaboratively and in cases such as the child protection process these failures have attracted wide publicity. Research funded by the Department of Health to examine the workings of the child protection system in England and Wales found evidence of considerable friction and tension in interagency working (Birchall and Hallett 1992, Birchall and Hallett, 1995). In particular, despite the recommendation that interagency cooperation should cover all stages of a "case career"; referral and recognition, immediate protection and planning the investigation, investigation and initial assessment, child protection conference and decision making about the need for registration, comprehensive assessment and planning and implementation, review and where appropriate de-registration, the evidence suggested that this was not happening (Hallett 1995). The research revealed different commitment to collaboration at different stages throughout the child protection continuum, with greater evidence leading to the conference and decreasing levels following this stage. Even at child protection conferences where collaborative working appeared at the optimum point, the researcher found evidence that on occasions cooperation was largely confined to information exchange and some shared decision-making. "…Less a case of joint working than of an agreed division of labour with a sequential ordering of tasks being undertaken by separate professions" (Hallett 1995: 326)

Hornby (1993) emphasises the need for a structural approach to collaborative working to be paralleled by a relational approach, one that is concerned with the

human element in working together. Hornby found a number of difficulties encountered in collaborative working as identified across sites reviewed and these included different professional cultures, different funding structures, potential overlap of roles and lack of understanding about the roles and responsibilities of different agencies and different levels of commitment between staff within the different agencies. It needs to be acknowledged that both of the research studies undertaken by Hallett and Hornby were prior to the publication of the Laming Inquiry, however the serious case review published following the death of baby Peter did not demonstrate that collaborative working had significantly improved.

There are many barriers to effective collaboration across professional and agency boundaries. These boundaries are wide ranging, including those between individuals, professionals and agencies. Hornby (1993) discussed a range of barriers to effective collaboration which include procedures, organisational structures which are not designed to facilitate trans-boundary relationships, the separate siting of various agencies, ignorance of other agencies and professions, narrow vision, different professional language, failures in communications, lack of trust between workers, rivalry between workers, conflicting opinions and attitudes and role insecurity.

Within safeguarding, the process of serious case reviews is intended to enable the multi agency arena to embrace the whole idea of a learning organisation. As valid as the argument may be, the key to developing collaborative ways of working, it would seem, is by linking systems thinking with sustainability. Sustainability, in this context, is the capacity of a system to engage in the complexities of continuous improvement consistent with deep values of human purpose. Developing system thinkers is an adaptive challenge. The key to moving forward is to enable leaders to experience and become more effective at leading organisations toward sustainability. The challenge in adopting collaborative working to safeguard children is not only about stating the nature of the destination but about acknowledging and analysing the complexity of this area of practice and thus the change process, whilst maintaining robust safeguarding practice during the change. This can only be achieved through sound approaches to risk assessment and management. The assessment and management of risk in

safeguarding children within the multi-agency context will be considered in chapter 4.

3.14 Collaborative working to safeguard children- moving forward

Moving towards collaborative working entails radical changes at various levels, including organisational structure, working processes and professional and organisational culture. Organisations and professionals working with families and children are at different stages of embedding collaborative ways of working, at strategic and operational levels. Barlow and Scott (2010) draw together, a number of concepts that can be applied at a number of levels, including organisational, practitioner and user, that are fundamental to a 21st century model of safeguarding, identified in research findings. These concepts are documented in Table 3.4.

Table 3.4: Conceptual underpinnings for a 21st century model of safeguarding (Barlow and Scott 2010)

From	To
Organisational level	
Service based	Outcomes-based
Child Protection focus	Child and family welfare approach
Tradition based	Multi-dimensionally evidence-based
Multi disciplinary	Trans-disciplinary
Systems	Complexity
Social constructionism	Critical realism
Practitioner level	
Systemic	Relational
Solution-based	Relationship-based
Expert	Partnership-based
Rule-based/procedural	Reflective
Child-centred	Family-centred
Child or parent-focused	Dyadic
Deficit based	Resilience/strengths-based
User level	
Isolationist	Transactional-ecological
Cognitive development	Social and emotional development
Authoritarian	Participatory

The concepts outlined in table 3.4 are based on current research findings and would promote a systems approach to achieving effective collaborative working. In reviewing the literature that relates to collaboration, it is clear that although this approach is advocated by policy-makers as the solution to failures within the safeguarding system, its achievement is challenging. The barriers to achieving effective collaboration within safeguarding include: unreasonable expectations by government, of what professionals can achieve within resources allocated, an aversion to risk within society and within organisations, professionals struggling with confidence levels and experiencing high levels of stress and high levels of

bureaucracy that inhibit time available for face to face practice. These issues are further explored in chapters 4 and 5.

CHAPTER 4
Risk and Risk Assessment

4.1 Introduction

This chapter will discuss the literature that examines the concept of risk within the context of multi-agency assessment and its relationship to the application of thresholds and decision making in child protection practice. The process of assessment, risk assessment and risk assessment tools and their use in child protection practice will be explored. The development of services for children and young people at both a national and local level as an integrated, multi-professional approach has resulted in a wide range of professionals becoming involved in the assessment and management of risk. In undertaking research that focuses on collaborative working between health and social care professionals, it is important to consider risk and risk assessment within that multi-agency context, and the effect that practice that focuses upon risk, has on collaborative working.

The system to protect and safeguard children in this country is the product of years of evolution in which the publication of the two Laming Inquiries (Laming 2003, Laming 2009) was a landmark event. In addition to these inquiries, the system has been shaped by numerous other inquiries (Brandon et al 2008), which have highlighted the failure of the multi-agency system to adequately assess risk and thus protect children. Decisions made in the field of safeguarding children are fundamentally concerned with the assessment of risk. An interagency approach to assessment and information sharing is viewed as central to the improved quality of decision making to safeguard children (Ward et al 2004). Ofsted (2009) undertook an evaluation of 173 serious case reviews carried out and completed between 1st April 2008 and 31st March 2009. In analysing the findings of the reviews, Ofsted found a number of risk factors present in the families that were the subject of the review, however, the agencies involved, repeatedly failed to adequately assess those risks. The current research project, in focusing upon collaboration, clearly identifies that for collaborative working to be effective, issues such as common language and agreed thresholds are key

components. A collaborative approach to the assessment and management of risk underpins the whole concept of safeguarding children.

The Children Act (1989), The Children Act (2004) and government guidance issued under its auspices (HM Government 2006a) seek to achieve a balance between protecting children from significant harm and working in partnership with parents. The extent to which the balance has been successfully achieved has been the subject of debate and of investigation by researchers (Department of Health 1995). One outcome of the refocusing debate emerging from the research findings was the publication of The Framework for the Assessment of Children in Need and their Families (Department of Health 2000). The Framework for the Assessment of Children in Need and their Families provides an holistic approach to identifying need, but one criticism levied at this framework is that it does not readily equip practitioners with a model for conceptualising and analysing risk.

Calder (2003), in discussing the use of the framework states that in failing to adequately address risk, concerns arise that this may result in the child's safety as the primary objective being overlooked. Donnelly (2001) concurs with this view and states that the concept of risk should be seen as part of everyday life with the term "risk" being an essential feature of our language. She goes on to say that its judicious usage, alongside informed understanding, could enhance partnership working with families and her view, therefore, is that the framework represents an opportunity lost to define the concept of risk. This, in turn, affects the ability to translate assessment conclusions into future hypotheses and plans as, according to Donnelly (2001), risk prediction is fundamental to needs based planning. In recognition of the fact that in an area where failure to adequately assess and manage risk the consequences may be devastating, one needs to assess the evidence, to consider, whether there is a need for the use of more sophisticated analytical tools than the Assessment Framework to assist professionals in judgement forming in relation to risk.

During 2009, the NSPCC commissioned a major piece of research to establish the extent of child maltreatment. The report of the research revealed that one in four of the young adults participating in the research, reported experiences of severe

physical violence, sexual abuse or neglect in childhood. The report raises concerns that the majority of child abuse is not detected, and raises questions as to what impact reforms in response to serious case reviews and public inquiries have in terms of the practice of assessment and the assessment of risk.

4.2 Risk

The concept of risk is socially constructed and according to Beck (1992), became a dominant preoccupation within western society towards the end of the twentieth century, with great emphasis on uncertainty, individualisation and culpability. Kemshall and Pritchard (1996) define risk as: the uncertain prediction about future behaviour, with a chance that the future outcome of the behaviour will be harmful or negative.

Risk is an ambiguous concept, the use of the term having changed over time. Historically, the term risk was used only to describe the probability of something happening. Therefore, it related to both positive and negative outcomes. In more recent times, it has come to be associated mostly with unwanted outcomes and this is evident in the field of child protection, where authors refer to the risk of harm to a child. In child protection, the concept of risk has evolved to become associated only with negativity or adversity (Hallett 1995). Its use in this way in the field of child protection presents a distorted picture, as the focus of the work is as much to promote children's welfare as it is to minimise harm. This focus on risk, and the practice of attempting to predict, whether or not a child will be abused, can minimise or overlook the reality, and impact of past and present abuse.

Risk is present in all aspects of health and social care practice and the management of risk underpins many professional decisions. However, it is a relatively recent concept in child protection practice. Child protection literature made no reference to risk and risk assessment in the 1950's and 1960's. In the 1960's the NSPCC promoted the work of two paediatricians from the USA, the Kempes, who had persuaded the legal and social welfare authorities in the USA that parents could physically harm their children. During this period, policies within the UK were developed in a similar vein to those developed in response to

the Kempes' work in the USA. As a result, child abuse was viewed within a medical framework and the response to child protection concerns was the development of casework as a means of intervening and "treating" families (Parton 1986). In 1985 the report into the death of Jasmine Beckford was published (London Borough of Brent 1985). Jasmine Beckford died at the hands of her step father whilst the subject of a care order. The report into her death highlighted a number of concerns including professional failure to take account of "high risk" situations. The procedural response to this review was the reframing of child abuse work as child protection work, which resulted in a shift from effecting change through preventative casework towards the need to assess risk and dangerousness within a child protection context. Within the policy directives and guidance documents from central government that focused on child protection with the intention of reducing the risk of deaths from abuse, the first attempt at introducing a risk assessment tool came in 1988 in the document commonly referred to as "the orange book" (Department of Health, 1988). This document formed the basis of local authority practice in the field of assessment in child and family work. Calder (2008) states that this central assessment guidance was built almost entirely on the notions of risks and dangerousness and yet, a decade later, risk was deleted from the central procedural and assessment guidance governing child protection (DOH 1999, 2000).

During the early 1990s a series of research studies on the functioning of the Children Act 1989 were commissioned by the government and were published in 1995 (DOH 1995). The Children Act 1989 and subsequent policy is discussed in chapter 2. The findings of the research studies commissioned to consider the functioning of the 1989 Act concluded that the pendulum had swung too far in that the focus of child protection practice was now focused almost exclusively upon risk and investigation, to the exclusion of assessing and providing services to children in need. The findings of this series of research studies was affirmed in another report (DOH/SSI, 1996) which described social work departments as continuing to respond to child protection and looked after children cases to the exclusion of families with children in need. It reported the focus as being too narrow and with the potential of neglecting the wider picture of need. This is recognised in the practice guidance Framework for Children in Need and their

Families (Department of Health 2000) which requires that any assessment of a child and family will take account of the three interacting domains, the child's developmental needs, the parenting capacity of the child's carers and relevant family and environmental factors. The framework makes no reference to risk or the assessment of risk. Calder (2008) expresses concern regarding this omission given that, on average, there is a report each week surrounding a child death to the Department of Health and Calder states that there is a need to take the opportunity of managing risk better rather than sidelining it.

Child protection work by its very nature involves uncertainty, ambiguity and fallibility and decision-making takes place in the context of a limited evidence base. Errors in decision making can have extremely serious consequences and frequently attract negative publicity. Initiatives such as risk assessment frameworks do not remove the risks but can be used to improve professional decision making.

4.3 Risk assessment

Risk assessment has been defined as the process of estimating and evaluating risk. In working with children it is a process that is used to determine the severity of abuse or neglect, in order to intervene and protect children from future harm (Cash 2001). Risk management is a systematic approach within an organisation, which allows for the planning of strategies and for monitoring and reviewing accountability and support (Titterton 2005).

Risk assessment contributes to the decision making process in child protection practice. Decision makers are portrayed by theorists as following a sequential process, putting time and effort into considering alternative actions, deliberating about the possible consequences and agreeing an option that is likely to satisfy the goal. In contrast, a number of studies that have considered how people actually reason, reveal a picture of reluctant decision-making, where the individual is beset by conflict, doubts and worry, thus resulting in procrastination, rationalisation or denial of responsibility for their own choice (Fish 2009).The picture of reluctant decision making is evident in child protection practice. Research and analysis of a number of serious case reviews has shown that one of

the most consistent findings in respect of fatal child abuse cases is the failure to undertake appropriate and adequate risk assessments. This finding was also a feature of the work of Dale et al (2005) which describes their research undertaken looking at professional judgement in cases where there are serious injuries to children.

Various studies and editorials have criticised the inadequacies in professionals' ability to assess risk and suggested that professionals must develop critical skills to enable them to assess risk (Corby 2003, Gambrill 2005, Dorsey et al 2008.) However, these authors fail to identify the specific skills that need developing and fail to identify what gets in the way of competent practice in assessing risk. Other authors view the issue differently and suggest the poor prediction of risk is due to risk incidents being rare and therefore suggests that predictions tend to be crude, as research studies continue to focus on completed events which cannot be generalised as accurate predictors (Hawton 2005). Recent research (Dorsey et al 2008), found that although assessments of risk were associated with some of the factors that have been shown to predict the recurrence of abuse, on the whole assessments were only slightly better than guessing. This study confirms that risk assessment cannot be used as a process for predicting risk. In practice, there are a significant number of children for whom the same risk factors are present as in the cases of children who suffer significant harm and yet they do not progress to suffer harm. This view is shared by Reed (1997) who states that professionals have a good understanding of risk factors, but have difficulty bridging the gap from general risk to specific risk factors. A number of authors share the view that in response to their poor predictive abilities, professionals become over cautious and restrictive in their practice (Monahan 1997, Bacon 1997, Taylor et al 2008).

Risk assessment may be considered through two distinctive models, the risk-taking model and the risk minimisation model (Davis 1996). The risk-taking model views risk as normal and positive and assessment focuses on mental wellbeing, rights, abilities, choice and participation. The risk minimisation model targets those most at risk and assessment focuses on physical health, danger, control and incapacity. Millar and Corby (2006) refer to a key element that these models fail to address, the therapeutic role of risk assessment which goes beyond

the narrow focus of information gathering. The importance of the therapeutic element of risk assessment is acknowledged by Dale and Fellows (1999).

It is important to acknowledge some of the very real problems that exist in undertaking risk assessment in child protection work. The concept of risk in this area of practice may be viewed from a number of perspectives; risk to the child of harm, risk to the family of intrusion, risk to the professional of blame and risk to the agency of blame and loss of reputation. Risk assessment is an area that presents conflict between analytic and intuitive approaches. Analytic approaches involve conscious and consistent thought whereas intuitive approaches involve rapid, unconscious data processing.

In reviewing the literature, research addressing different approaches to the assessment of risk has occurred in a number of disciplines including mental health and criminal justice. The literature generally describes three approaches: the Actuarial, Clinical and Theoretical Empirically Guided approaches. Calder (2008) differentiates between the first two approaches, Actuarial and Clinical, and discusses their use in making clinical judgements. Actuarial risk assessment is based upon statistical calculations of probability and predicts an individual's likely behaviour from the behaviour of others in similar circumstances. Grove and Meehl (1996:293) state that Actuarial assessment involves a formal algorithmic, objective procedure to reach a decision. Clinical risk assessment is traditionally based upon the subjective judgement of key professionals and, according to Grove and Meehl (1996:294), relies on an informal, "in the head", impressionistic, subjective conclusion reached by a human clinical judge. This approach allows for the consideration of plausible risk factors present in an individual case that may lack documented empirical support (Hanson and Thornton 2000). The two approaches are presented as distinctly opposing, which reflects a similar view on the difference between analytic and intuitive thinking. Hammond (1987) presents a different view and uses the term cognitive continuum in describing the range of practice from Intuitive judgement through to Actuarial judgement. This approach recognises that in complex areas such as some safeguarding scenarios, the optimal approach is to combine the different forms of judgement.

Research that has been undertaken to evaluate the effectiveness of both Clinical judgement and Actuarial approaches found Actuarial tools to have shown a higher level of accuracy and consistency than Clinical judgement approaches (Hanson 1997). In reviewing 136 studies, Grove and Meehl (1996) found only eight studies in which predictions using Clinical judgement were more accurate than actuarial instruments.

Actuarial assessment has been less developed in child protection work and Kemshall (2001) summarises the concerns that research literature has identified with this particular methodology. The concerns identified are: firstly, the limitations of extrapolating individual risk probabilities from aggregated data about groups, or statistical fallacy. Secondly, the limits of the research techniques used to produce risk predictors, or meta-analysis, and, thirdly, the limit of low base rates that are predicting general risk probabilities from low frequency behaviour.

Clinical assessment is also identified by Kemshall (2008) as displaying certain problems, which include subjective bias of the assessor, staff taking short cuts when under pressure, over-identification with the subject of the assessment and over-reliance on the self report of the subject of the risk assessment. These findings have been recurrent themes in serious case review reports. Munro (2002) reflects the view of Hammond (1987) and suggests a framework for assessing risk through a structured approach, using both actuarial and clinical components. This framework helps to make explicit the likelihood and undesirability of an outcome, with the use of intuitive judgements based on facts. This approach is advocated by White and Walsh (2006), who use the term" a third generation approach" , an approach which consists of empirically validated structured decision-making or structured clinical judgement. The approach attempts to bridge the gap between the scientific, actuarial approach and the clinical practice of risk assessment (White and Walsh 2006). The approach involves the development of evidence-based tools that promote accountability but encourage the use of professional discretion.

Monahan (1997) advocates that the model that best predicts risk is that using statistical (actuarial) techniques. He bases his assessment on the use of the approach in criminology where he reports its use as successfully predicting risk; however it cannot be assumed that findings from its use in criminology can be automatically transferred to the field of safeguarding children. Although Monahan (1997) cites the success of such approaches in the field of criminology, in reviewing literature in the area of risk assessment for this study there appeared to be a lack of research evidence to determine the degree to which actuarial predictions can be applied to other populations including children at risk. Appleton and Cowley (2003) undertook a study to examine health visitors' use of professional judgement and formal guidelines in identifying, through assessment, families requiring an enhanced health visitor service. The study focused specifically on the health visitors' use of professional judgement in the assessment of family health need. The study used a case study strategy informed by a constructivist methodology and then used in depth interviews with participants across three sites. A key finding was that even when guidelines exist, most health visitors use their professional judgement in making assessments.

In the context of child protection, a risk assessment aims to assess factors that may be associated with a child suffering from abuse. However, a distinction needs to be made between immediate and long-term risk in terms of the urgency of response. The political and social pressures to prevent child death or serious injury have resulted in some types of abuse receiving more public attention than others. Abuse that carries immediate risk such as physical abuse tends to be placed higher on the agenda than the types of chronic abuse that produce serious problems in the longer term such as emotional abuse. This in turn results in different responses to different types of abuse with responses to physical and sexual abuse receiving more urgent response than emotional abuse or chronic neglect, despite the research base suggesting that the latter is extremely harmful to the individual's development (Gibbons et al 1995). Research by the Department of Health (1995) clearly demonstrates this. This research revealed that many families who were assessed appear to experience significant long-term problems in caring for their children adequately, but are offered no services unless an immediate risk was identified. Borum et al (1999) reviewed 58 studies

from a range of social science disciplines and found that Actuarial methods of assessment were better at predicting long term (a year or more) outcomes, but that clinical methods of assessment were comparable in predicting outcomes if the outcomes were less than one year.

4.4 Risk assessment tools

There are a range of assessment tools available to the practitioner, most of which involve a form or table which the worker completes either on a one-off basis or over a period of time. It is important to acknowledge that risk assessment tools, are in essence risk classification tools, rather than abuse prediction tools. It is important to evaluate the tool to assess how it performs in the specific area of practice, to ensure accuracy and inter-user consistency.

Research undertaken in the USA found that most instruments in use had not been empirically validated (Johnson 1996, Lyons et al 1996). On the whole, these tools were developed using expert opinion and a literature review rather than empirical studies of the prevalence of factors among abusers and the general population. There is specifically a lack of empirical study of the factors that predict re-abuse.

Because of the reliance on expert opinion, the instruments are diverse. The number of factors identified varied greatly in number and no factor appeared in every instrument. The range of factors identified include factors that relate to parents, including age, marital status, parental difficulties such as substance misuse and factors that relate to the child, including age and disability. The tools also claimed to be able to predict all categories of abuse, which, given the diverse nature of abuse, appears doubtful. Another key judgement required is the extent to which the tool is culturally sensitive.

One of the key arguments presented for the use of risk assessment tools is to increase consistency within and across agencies. This was one of the key aims of the assessment framework, to make the process more workable across agencies by utilising a common language and process. In practice, this has not worked consistently but has, in practice, become predominantly a social work task. A

number of agencies have in fact developed their own assessment tools, ignoring the assessment framework, including ASSET, used by the youth offending team and OYSIS, used by probation and for high risk domestic abuse assessments as part of the multi agency risk assessment conference, the use of risk assessment tools developed by CAADA. However, what would appear to be more important is the impact any tool used has on practice. There is a lack of research studies available that clarifies this. The studies that have considered this aspect demonstrate disappointing results. Fluke et al (2001) found that there was a general sense that risk assessment was largely peripheral to work with clients.

4.5 Making decisions

Child protection work inevitably involves working with uncertainties and the need to make decisions, based on incomplete information. Decisions are fundamentally concerned with the assessment of risk and depend on cooperation and communication across agencies. The fundamental principle in risk management is the ability to assess and identify the risk involved and to reach a decision on how to manage the risk effectively. Decision-making therefore involves making a judgement about the risk presented and the possible outcome, then deciding what to do about it. Pitz et al (1984) assert that decision-making is an activity which involves a sequential process of the presentation of a problem, important features identified, other information retrieved from memory, and organisation of the information in a meaningful way. The individual then explores and classifies the decision situation to ensure they understand the relevant objectives and values, formulates the situation or behaviour presented; then generates alternative solutions. The decision maker then chooses a single alternative or attribute or compares alternatives, evaluates the different benefits and makes a judgement as to what is best. The process described by these authors thus involves recognition, formulation, alternative generation, information search, judgement or choice, action and feedback. Gambrill (2005) presents an opposing view arguing that decision makers do not always follow a rational process, but instead that decision making involves a shorthand mental activity of recognition, structuring decision situations and the evaluation of preferences to produce a judgement and choice. Gambrill uses the term confirmation biases to describe the practitioner, searching only for information that supports their preferred view.

This theory is supported by Munro (2008:137) who states: “the single most pervasive bias in human reasoning is that people like to hold on to their beliefs”

Research in the area of decision-making can basically be divided into two schools: the decision theorists who draw on probability theory and logic to prescribe a model for decision-making and the naturalists, who aim to describe how people actually make decisions. These two approaches broadly reflect the split between Actuarial and Clinical approaches to assessing risk. Decision making in the field of child protection draws upon the work of both decision theorists and naturalists.

Before a professional can respond to the problem presented they must understand the information and develop a representation of the problem. Decision-making in risk management involves critical thinking to enable the professional to make a judgement about the risk presented to the child. Dalzell and Sawyer (2007) support the view that knowledge is necessary in critical thinking and discuss the need for professionals’ to carry out a “cultural review”; In referring to a “cultural review,” the authors suggest, this process, enables the professional to alert themselves to any areas, where their assumptions, prejudices or lack of knowledge may impact. It may be assumed that practical knowledge is only developed through clinical experience; however Tanner et al (1993) acknowledge the importance of experiential knowledge in enabling the recognition of patterns and intuitive responses to expert judgement.

The models of professional knowledge described by Drury-Hudson (1997) and Munro (2002) detail how decisions and risk identification are affected by factors including formal knowledge, values, reasoning skills, emotional wisdom and practice wisdom. Formal knowledge derived from training includes knowledge of the law, policies and procedures as well as covering a range of theoretical knowledge and research about child development, family dynamics and methods of intervention. In discussing values, Munro describes the ethical framework in which all aspects of work need to be seen, including awareness of discrimination. Reasoning skills relate to the ability to reflect critically on one’s practice and reason from one’s experience and knowledge. Emotional wisdom refers to the

ability to understand and deal with the emotional impact of the work, an area explored in greater depth in chapter 5. The final factor, practice wisdom involves the development of skills to make sense of one's own and others' behaviour through understanding social norms, cultures and diversity.

In child protection work, the reluctance to make decisions can result in decisions being made in the context of crisis rather than through long term planning (Burton 2010). This is particularly evident in the reports that consider serious case reviews, particularly when they are work load pressures (Brandon et al 2008). Burton (2010) states that agency policies and prevailing culture and ethos can either exacerbate or mitigate this problem. In practice a lack of process in decision-making leads to inconsistent application of thresholds and thus interagency disagreement.

Many of the texts that consider decision-making focus upon the intellectual difficulties (Marsh and Triseliotis 1996) and although many decisions in child protection work are intellectually challenging, they are also emotionally challenging, in that they are likely to cause distress to those involved and the fact that professionals know that in many cases they are only able to offer imperfect solutions. This aspect is often not acknowledged. This is discussed further in chapter 5.

A number of strategies for decision-making are documented in the literature, including pattern recognition and satisficing. Satisficing is a strategy that was first described by Simon (1957) and the term is used to describe the situation when making a choice from a set of options, setting the criteria as to what is good enough and stopping when an option exceeds the good enough level. In summary, this approach proposes that it is rational to choose the option that has a satisfactory outcome. The use of this is beneficial in terms of resource efficiency. Simon (1957) argues that this approach is superior to formal decision making in that it better matches the range of reasoning skills. This approach, however, still requires judgement in terms of the standard of what constitutes good enough. In familiar areas of child protection, experienced practitioners are almost certain to use this approach, as decisions about the thoroughness of the investigation, when

to stop searching for more evidence and when the assessment is good enough, are types of decisions where an experienced practitioner can draw on past experience. It becomes more challenging when, in cases of inexperienced practitioners, the relevant experience to sharpen the intuitive judgements is lacking (Gigerenzer et al 1999).

In reviewing the literature, it is apparent that the assessment of risk to a child or young person is fraught with difficulty. In considering the application of research findings, professionals have the choice between an actuarial or intuitive approach in assessing risk and making decisions, discussed earlier in the chapter. At best, an actuarial instrument will help in making a judgement about the level of risk to a child in a particular family at a particular time. Risk assessment in the practice of child protection, in line with other assessments, needs to be an ongoing, not a one off event, to reflect the changing nature of families. Fundamental to the assessment of risk is the detailed collection of information and the analysis of that information. This can only be achieved through effective collaborative working and information sharing. Once information has been gathered and analysed, the next stage of effective risk assessment is to determine what interventions may reduce or manage the risk, with a clear understanding of what needs to change and how that change might be accomplished. Given the complexity of cases within a safeguarding system, it is not possible for one professional or one agency to be well versed in what works in the case of every challenging case they face. It requires the ability to draw on a range of skills across the multi-agency network. The importance of effective communication and working between professionals in the assessment process is acknowledged by Reder and Duncan (2003), who describe the need for mutual respect and detailed information sharing.

Errors in communication can have serious consequences. Munro (2008) describes a range of errors in natural reasoning in child protection decisions that underline the importance of cooperation and communication. The errors discussed include failure to revise risk assessments, basing decisions on incomplete information, failure to collate information and failure to use historical information. Robust assessment and decision making in safeguarding children depends on good internal and cross agency practice that draws on the most up to

date knowledge base. Assessments are fallible and need to be viewed within a context of constant change. There is a tendency to persist in initial judgements or make assessments which fail to take account of changing circumstances or new evidence. It is therefore important that practitioners are willing and supported to challenge and review their assessment and views throughout any period of intervention. This can be achieved through effective supervision of practitioners, which is discussed in chapter 5.

4.6 Risk and thresholds

In different cultures, social classes, and geographical areas and between different professionals, very different views exist about what constitutes an acceptable level of risk to a child and what level of risk warrants professional intervention. In child safeguarding practice, different agencies, individually and collectively, operate various thresholds as follows:

- The threshold at which the Common Assessment Framework identifies a child as having additional needs
- The threshold at which a family is accepted as being in need of services.
- The threshold at which the names of children become subject to a child protection plan (Department of Health, Home Office, & department for Education and Skills 1999:55).
- The threshold at which care proceedings are initiated (Children Act 1989, Section 31).
- The threshold at which use of an Emergency Protection Order (*Children* Act 1989, Sections 44-6) is considered to be warranted to remove children immediately from home.

The practice of assessment including assessment of risk will lead to the need for a decision about thresholds for intervention, and it is the threshold which will therefore have a greater influence on outcomes as opposed to the risk assessment. To demonstrate this, if the threshold for intervention is too high this may result in cases where the risk to the child or young person is relatively high but services are not provided. Francis et al (2006) suggest that cooperation between agencies varies in different geographical areas and equally differing agencies have different values, cultures and interpretation and language about risk. These variables impact upon the application of thresholds and the level of trust and confidence between agencies. Francis et al (2006) describe their findings in relation to thresholds of risk within agencies as varying, and note that older, more

experienced workers operate at a higher threshold of risk than their recently trained counterparts.

Beckett (2008) differentiates between false negatives, false positives, true negatives and true positives in child protection work. These are discussed earlier in the chapter in relation to the evaluation of risk assessment tools. True positives are described by Beckett (2008) as where protective action is taken to prevent an adverse event that would otherwise have occurred and false positives as where protective action is taken even though, in fact, the adverse event would never have occurred if action had not been taken. True negatives are defined as where protective action is not taken and the adverse event never happened and false negatives as where the protective action was not taken but where the adverse event did actually happen.

When the false negative is the fatal injury of a child, professionals are often the focus of negative media attention. False negatives are clear to see with the benefit of hindsight whereas this cannot be said for false positives as it is not certain that the event would have happened. It therefore needs to be acknowledged that a threshold can only be a line drawn across a period of probability and not a line that clearly defines families that will definitely harm their children and those that definitely will not. This compounds the challenge faced by professionals in different agencies acting upon different threshold levels, despite the intention of undertaking multi agency assessments.

4.7 Risk aversion

One of the reasons that child protection work is viewed as an area of practice that poses high levels of risk to professionals is its politicisation, and consequently the media attention, particularly in light of the number of high profile tragedies. Child abuse and deaths touch aspects of our personalities that at best feel less than comfortable, and may result in a sense of denial. Cooper et al (2003) describe how practitioners find it relatively easy to deal with the more obvious risks, even when these are high, as the expectation of the professional in such circumstances is clear. Where the risks are implicit rather than explicit or the case is more complex, professionals feel much less confident and, according to

Cooper et al (2003), fall back into denial, optimism, a checklist mentality or the use of other unhelpful defensive risk avoidance techniques. Alaszewski and Manthorpe (1998) found that child care agencies were more defensive and reactive, whereas learning disability agencies were more open to learning and advice, partnership orientated and keen to anticipate risk. Their research examined how organisations responded to risk. SCIE considers more effective approaches from learning from mistakes (Bostock et al 2005), and uses the analogy of "near misses" from the aviation industry to emphasise the need for interagency collaboration and information sharing so as to learn from past mistakes. The SCIE report concludes that the current culture of blame does not encourage best practice in the field of safeguarding children.

Different organisations have different requirements for risk assessments, and different values and philosophies on which such assessments are made. Nevertheless, they have to work in collaboration with other agencies in order to fulfil the terms of their duty of care to clients and the public. It is also essential for effective risk assessment that all agencies share and collaborate on the evidence collected and review it on an ongoing basis. McIvor and Kemshall (2008) views this collaborative approach more sceptically, stating that, for some stakeholders, it is used to avoid any one agency being held accountable for adverse outcomes, which suggests a risk minimisation approach to risk assessment rather than a risk taking approach. It also suggests a reactive approach to collaborative working as opposed to a proactive one. There is clear evidence (Parton et al 1994, Paton and Violanti 1996) that working in an area of practice that requires constant judgement in relation to risk and risk taking, which may at times have catastrophic results, leads to high levels of stress for professionals across agencies. In chapter 5 the emotional impact for workers working in child protection will be considered, and the effect this has on collaborative working. The notion of professional resilience will also be discussed.

In this chapter risk assessment within the context of multi-agency practice has been explored. The centrality of information sharing and communication between professionals and agencies to achieve robust assessment, of which risk assessment is an essential element if children are to be safeguarded, has been

discussed. Chapter 5 will explore the literature that considers the roles of both health and social care professionals within the context of their work that contributes to safeguarding children. The emotional impact of such work will be explored and the impact this may have on effective collaborative working will be discussed.

CHAPTER 5

Safeguarding Children – The Roles and Responsibilities of Professionals

5.1 Introduction

The Children Act 1989 (DOH 1991) provides the legal framework for protecting children. Local Authorities have a responsibility to safeguard and protect children in collaboration with other agencies. The more recently published guidance Working Together to Safeguard Children (HM Govt 2010) aims to explain the roles, responsibilities and duties of professionals involved in safeguarding children, including health Professionals and social care professionals. Additionally, the Children Act 2004 creates a duty of all such agencies to cooperate to improve the well being of children (section 10) and to safeguard and promote their welfare (section 11). This therefore extends the responsibilities and duties of other agencies. Following the consultation on the green paper, Every Child Matters, there was general consensus that, for professionals working with children and young people there should be a common set of skills and knowledge. This resulted in the development and publication of a common core of skills and knowledge for the children's workforce (HM Government 2005). The common core reflects a set of common values for practitioners with one of the aims being to improve the integrated approach to service delivery by helping to develop a greater shared language and understanding across the workforce. This chapter will explore the concept of professional roles in relation to safeguarding children. Although consideration of the roles of professionals at an operational level is important, it is also important to consider roles at the macro level in terms of central government and the role of inspection bodies. The roles of professionals who were included in the research, social workers, GPs, health visitors and school nurses, will be specifically considered and issues around conflict which may militate against collaborative working will be explored. Laming (2009) recognises the demanding task facing front line workers and states that, in addition to knowledge and skills, practitioners require determination, courage and an ability to cope with sometimes intense conflict in order to undertake safeguarding duties effectively. Laming goes on to stress the need for practitioners' managers to recognise the fact that anxiety

in practitioners undermines practice. The emotional impact of the work of safeguarding children will therefore be discussed.

5.2 Role theory

In order to consider the roles and responsibilities of professionals, it is important to consider the theoretical basis of roles. Definitions of roles and responsibilities are open to wide interpretation. In simple terms, role may be viewed as one's task or function and responsibility as the area for which one is answerable for one's actions. Role theory is one of the most pertinent theories which can provide explanations for the behaviour of individuals and how that may impact upon inter-professional work. Cohen (1994) states that role theory dates as far back to the period of time that Shakespeare was writing and states that it was Shakespeare who noticed that individuals act out different roles at different ages. In referring to role theory, there are several formulations applicable to this concept. Biddle (1986), in considering roles, describes four separate perspectives, namely functional, symbolic interactionist, structural and organisational. In analysing the roles of health and social care professionals, elements of each of those theories will be drawn upon. The four perspectives each consider roles from a different approach:

- Functional
  This area of sociology grew out of cultural anthropology and sees society and social relations as a system of parts that are connected to each other and to the system as a whole
- Symbolic interactionist
  Manis and Meltzer (1972) describe the work of Mead in this area and describe the approach as one where human beings interpret or define each other's actions, not merely reacting to stimuli
- Structural
  Manstead and Hewstone (1996) describe structural role theory as providing the concept for the roles people are expected to play. They state that when acting in their allocated roles individuals are expected to do so in different interrelated ways according to the functions of the structures they are part of.
- Organisational
  This approach to role theory considers linking theories about individuals to theories about organisations. Handy (1993) states, that the performance of an individual, will, in carrying out their role will be influenced by his or her personality, attributes, skills and situation. This approach explores role theory by considering different concepts including role ambiguity, role

incompatibility and role conflict. This perspective is relevant when attempting to consider individuals as key members of organisations.

Role theorists see the norms that define social position as learned through a process of socialisation. It is important to recognise that improvisation and negotiation are essential features of the construction of social action. In considering the roles of different professionals who have a responsibility to safeguard children, these influences will be further demonstrated.

5.3 From strategic to operational roles in safeguarding children

Laming (2009) describes how effective leadership sets the direction of an organisation and goes on to state:

"It is essential that there is a sustained commitment to child protection and promoting the welfare of children at every level of government and in every level of the local services."
(Laming 2009:14)

Prior to the Laming (2009) report the importance of leadership in ensuring robust safeguarding arrangements had not been clearly recognised. In his progress report on safeguarding, Laming (2008), stated that managers must lead by example and take a personal and visible interest in frontline delivery. He went on to challenge senior managers by expressing concern that they did not have sufficient skills or experience to scrutinise or challenge practice sufficiently and made recommendations to the DCSF accordingly.

Ultimate responsibility for shaping a national safeguarding system for children and young people lies with the Minister of State for Children and Families in the Department for Education. In fulfilling this strategic role, there needs to be a clear understanding of what the true measurements of effective intervention are that results in improved outcomes for children and young people. This requires a closer connection between strategic and operational role holders, both in identifying relevant performance indicators and in ensuring those involved in the delivery of services are clear as to what they are being measured against.

The issue of a lack of common understanding of what is being measured was evident in the first annual report of the evaluation of serious case reviews (Ofsted 2008), which judged a number of serious case review overview reports and individual agency management reviews to be inadequate. However, in a number of cases, authors had not been made aware of the newly developed criteria they were being assessed against and the criteria used have subsequently been questioned (Laming 2009). Laming also reported that there had been an over-emphasis on measuring process rather than outcomes or degrees of learning. It needs to be acknowledged that the heightened focus on governance in the field of safeguarding children, particularly within local authorities, has developed in recent times, and the extent to which such arrangements become embedded in practice will need assessment over time.

At a local strategic level, the roles of lead members for children's services, i.e. councillors, and the Director of Children's Services, are seen as key in providing leadership locally to ensure children are safeguarded. DCSF (2008a) launched a consultation, Statutory Guidance: The Roles and Responsibilities of the Lead Member for Children's Services and the Director of Children's Services, which resulted in the updating of the 2005 guidance. The guidance aims to explain how the roles are distinct and complementary and how by working together they can be most effective in leading change that results in improved outcomes for children and young people. In practice the responsibility and interrelationship of the two roles is not always clear to professionals working at an operational level and in order to effectively safeguard children, clarity regarding roles is key. The distinction between the two roles is also, at times not clear to senior managers. One issue that demonstrates this lack of clarity is their roles in relation to the functioning of safeguarding boards. The chair of the LSCB, although independent is accountable to the Director of Children's Services but is expected to challenge their work as part of their role. The Lead Member should be a "participant observer" of the LSCB (paragraph 2.17), which in itself raises questions as to how this should be interpreted. Reporting and accountability arrangements remain unclear and open to interpretation despite the best intentions of the new updated guidance to clarify the roles and responsibilities of these key roles.

5.4 The Role of health professionals in safeguarding children

Health professionals play a critical role in safeguarding children, however as Ayre (1998) suggests, little guidance is available to support them in judging what constitutes 'significant harm'. The second joint Chief Inspectors Report on Arrangements to Safeguarding Children (Joint Chief Inspectors 2005) identified the need for NHS organisations to have clear guidance on role definitions for health professionals who take specific responsibilities for safeguarding children. The clarity of roles across the health economy has been the subject of variation. This is further complicated by the status of professionals as either direct employees or in the case of general practitioners, independent contractors.

General practitioners provide a service that in the majority of cases is a contracted service and, traditionally, commissioners have had limited opportunity to influence safeguarding practice, with a high percentage of general practitioners delivering services in line with the national contract. This does not promote the development of local variation of safeguarding standards in response to local issues such as serious case reviews or audit findings. Whilst Working Together to Safeguard Children (HM Govt 2010) clearly describes the important role general practitioners have in safeguarding children, the issue of medical confidentiality is frequently cited as restricting the full participation of this group of professionals in the safeguarding process.

In terms of the role of general practitioners, the primacy of the doctors' therapeutic function is self-evident and the confidential nature of their relationship with their patients is strongly embedded. It may be that professional adherence to this has resulted in a reluctance to act in a regulatory capacity for the state (Bury and Elston 1987). GPs have also not been used to balancing the needs of more than one patient, the parents and the child. Working Together to Safeguard Children (Department of Health 2010) clearly documents the key role general practitioners have to play in the identification of children who may have been abused and those who are at risk of abuse, as well as a role in subsequent intervention and protection. It also describes their role in recognising when a parent or other adult has problems that may affect their capacity as a parent or carer, or that may mean they pose a risk of harm to a child.

Despite the recognition of the central role general practitioners have in contributing to the safeguarding of children, available research suggests that the investigation of child protection cases is frequently hampered by the lack of medical evidence and the low rate of attendance of medical personnel at child protection conferences (Armstrong 1995, Farmer and Owen 1995). Other research findings have stated that not only are general practitioners the single largest group of non-attendees at child protection conferences, but they are also less forthcoming with relevant information than other professionals (Simpson et al 1994, Birchall and Hallett, 1995, Farmer and Owen 1995). More recent research findings (Tompsett et al 2009), revealed, an ongoing trend, of non-attendance at conferences by general practitioners, although there was an improvement in general practitioners submitting reports. Kennedy (2010), undertook a review of children's services in the NHS, and the resulting report identified that children and young people were not "getting the best deal", and that in many parts of the country, 40-50% of general practitioners, have little or no experience of paediatrics as part of their professional training, despite the fact that 25% of their patients are children.

In view of the research findings about the failings of this group of professionals, the reasons for this need analysing. Bannon et al (1999) describe the unique relationship that general practitioners share with their patients and how challenging parents with child protection concerns may potentially damage that relationship. The issue that Bannon et al describe is, in practice, however, not unique to general practitioners and poses the question that if a parent is not challenged in order to preserve the professional relationship, whether the relationship is worth preserving. From a professional perspective, it is important that there is absolute clarity regarding the role of any professional, so that the patient is clear about the professional's obligation to safeguard children and the fact that the welfare of the child or young person is paramount.

General practitioners do not have the same exposure to children, nor the level of specialist training as paediatricians and therefore cannot be expected to have the same degree of confidence in making clinical judgements. Lupton et al (2000) undertook research to consider the role general practitioners played in protecting

children and although their findings cannot be applied to the wider population as the sample consisted of only 100 general practitioners, they found that fewer than two cases a year of child abuse or neglect present to a GP.

In some cases, the general practitioners may have little knowledge of the child and the family members (Simpson et al 1994) and therefore feel unable to make any significant contribution. A number of general practitioners still practise in single handed practices and attendance at conferences, which may overlap with surgeries, poses a challenge. Another key issue identified by researchers is the lack of or inadequacy of training received by general practitioners on the subject of child protection. Bannon et al (1999) undertook research with 1000 GPs participating in the survey. They found a number of unmet training needs amongst those practitioners which included legal aspects of child protection work, intervention procedures and the role of other agencies. Without a clear understanding of the legal context of safeguarding, practitioners may be left feeling vulnerable if required to share information that is usually deemed as confidential. The issue of failure of general practitioners, to access child protection training, was identified by Lazenbatt and Freeman (2006). However, training attendance in itself does not guarantee improvement in practice, and methods need to be implemented to assess practice change as an outcome of training. The survey undertaken by Lazenbatt and Freeman (2006) identified a range of other issues affecting the engagement of general practitioners in work to safeguard children. Issues identified include: low reporting rates when abuse is suspected, lack of knowledge regarding reporting mechanisms, experience of case closure in past cases reported to social care, the fear of getting it wrong and the fear of litigation.

Another study undertaken by Polnay (2000) confirmed that, for many GPs child protection conferences are not a priority and attendance by GPs will not improve merely by overcoming practical reasons for lack of attendance. Polnay identified the need for better communication between other professionals with GPs to promote GP participation with the conference process. One solution proposed was the presentation of information held by the GP through the key worker. This needs careful consideration if the key worker is a social worker, as medical information may be incorrectly interpreted.

It was not until 2002 that the first position statement concerning the protection of children from abuse and neglect in primary care was published (Carter and Bannon 2002), with suggestions as to how primary health care teams can develop this important area of practice. Following the death of Victoria Climbiè, NHS organisations were required to conduct self assessments of safeguarding practice. In the reporting of an audit of GP safeguarding practice, Afza et al (2007), found that there was poor understanding of referral pathways, policies and procedures and that GPs knowledge of the function of designated and named health professionals was poor. The challenge faced by GPs in fully engaging in safeguarding work could be addressed in part by clearer links with other members of the primary health care team and by clarifying their prospective roles in relation to safeguarding. Nevertheless, this should not mean that GPs defer to other professionals, as it is essential they retain their own accountability.

Health visitors remain part of universal services and this universality places them, in an ideal role to identify potential family stresses at an early stage.

"The primary focus of health visitors' work with families is health promotion. Like few other professional groups, health visitors provide a universal service which, coupled with their knowledge of children and families and their expertise in assessing and monitoring child health and development, means they have an important role to play in all stages of family support and child protection" (Department of Health, Home Office & Department for Education and Skills 1999, section 3.35)

This is not the same for school nurses, whose roles in many parts of the country are focused upon children within the state school system. The evidence of the role health visitors and school nurses play in safeguarding children is somewhat mixed, and studies reviewed as part of the literature search for the current research were found to focus less on the role of school nursing than on that of the health visitor. The Working Together to Safeguard Children document (HM Government 2006a) made little specific reference to the role of health visitors and school nurses in safeguarding children; however the 2010 version contains more detail. In the

international literature, both nurses and health visitors are widely characterised as screening agents or observers and sometimes as evaluators or diagnosticians of abuse. In line with the commitment made by the government to undertake a biannual review of cases that had met the criteria for a serious case review, the findings of these have been published (Sinclair and Bullock 2002, Rose and Barnes 2008, Brandon et al 2008, Brandon et al 2009). It is clear from the findings of these reports that health visitors have often had more involvement with the families of the child or young person who has died or suffered a life threatening injury, than most other professionals including social workers. The 2005-2007 Biennial analysis of serious case reviews (Brandon et al 2009) identified that 30% of the subject children were under 3 months of age and 50% were less than 1 year old at the time of death or serious injury. This revealed a similar distribution of age range in the findings of the previous Biennial report (Brandon et al 2008) and reinforces the importance of the safeguarding role of health visitors and midwives working with young babies and their families, as noted by Laming (2009) in proposing "progressive universalism", which offers a more targeted health visiting service to families assessed as having greater levels of need. This does, however, rely on good assessment practice in the antenatal period, as if this need is not identified ante-natally or shortly following birth, the child will not get access to this additional support and monitoring by health professionals. Research has also found the role of health visitors to be one of the most participative roles in the inter-agency process of protecting children (Simpson et al (1994), and health visitors, among the most frequent health professionals to attend child protection conferences (Hallett 1995). However, other earlier studies highlight conflict and confusion between health visitors and social workers in relation to their respective roles and responsibilities (Fox and Dingwall 1985).

There appear to be very few studies that have specifically considered the role of school nurses in contributing to the safeguarding of children and young people. Lightfoot and Bines (2000) undertook research which aimed to identify and describe the distinctive role of the school nurse in working to keep school children healthy. The researchers used semi-structured interviews with a sample of seventy eight participants including school nurses, school heads and teachers, NHS Trust managers and commissioners. They also used focus groups to elicit the views of

young people of secondary school age and their parents. Key elements of the school nurse role were identified including the role played in safeguarding the health and welfare of children.

The development of the roles of health visitors and school nurses in the public health domain places their role as central in terms of the wider concept of safeguarding, with the role spanning the whole continuum of primary, secondary and tertiary prevention in the field of safeguarding. The roles of health visitors and school nurses rely on a partnership approach with parents and young people and this approach may result in a conflict, similar to that described for general practitioners, between the advisor role and the responsibility to report safeguarding concerns (Lupton et al 2001).

A range of home visiting schemes that aim to promote and safeguard children's health and wellbeing, whilst working in partnership with parents, are being promoted through government departments and are often based on those which have been used in the USA. Evaluation of such schemes has reported a reduction in the incidences of abuse and neglect, reduction in the rate of accidents and a reduction in visits to accident and emergency departments by children (Barlow et al 2003, Olds et al 1986)

Elkan and colleagues' (2000) review of the effectiveness of health visiting identified a number of benefits associated with home visiting, including improvements in parenting skills and the quality of the home environment. As well as promoting the well being of the child by working in partnership with parents, the role of the health visitor in safeguarding children has been widely acknowledged in terms of their ability to provide support and advice to parents when there are early indications of difficulties (Hendry, 2002).

5.5 The Role of social workers in safeguarding children

Social work is an established professional discipline with a distinctive role to play in promoting and securing the wellbeing of children and young people. It operates within a framework of legislation and government policy. Social work roles and responsibilities tend to be described by the nature of the work they undertake (Vass 1996). Child care social workers are often challenged with the role of negotiating the legal boundaries between the rights and responsibilities of the state with those of the family in the discharge of their parenting responsibilities.

Social workers have statutory responsibilities for child protection; they therefore embody the caring and controlling functions of the state in a necessary balance. Social work practice takes place within a context of situations where there are high levels of complexity, uncertainty, stress, conflicts of interest and risk. Social workers identify with the caring elements of the protective function and their professional ideology emphasises the importance of engagement with clients in a voluntary therapeutic contact. Therefore, social workers may be uncertain about the effectiveness of child rescue and uncomfortable about the extreme of legal orders to remove children (Birchall and Hallett 1992a). Some Children's Services have tried to reorganise their teams into those requiring a differential response, i.e. supportive advice work versus child protection cases. Whilst this may be possible from an organisational perspective, this is not necessarily ideal from the service user's perspective, as service users may view authority more broadly, based on their own experiences and assumptions. The constructive use of authority is an important but problematic strand in social workers' professional training and orientation.

5.6 Role ambiguity and conflict

Handy (1993) defines role ambiguity as occurring when an individual , or those involved with an individual, are uncertain about where the individual's role is at any time. Rawson (1994), states that roles can only be carried out by carefully avoiding conflicting areas of work. The interface between the health and social elements required in safeguarding children are not always clearly developed and therefore result in potential ambiguity and conflict between roles. Huxham and

Vangen (2005) estimate that it typically takes 2 ½ years for relationships to become sufficiently well established and trusting to support effective collaborative working. This can pose a challenge when workers are changing, due to staff leaving posts, and, in addition, the current climate has resulted in frequent changes to organisational structure. These changes mean that new professional relationships constantly need to be established. It can be difficult for workers to fully comprehend the role of others who have been exposed to different training, work experience and culture. Role conflict is commonly a feature of inter-professional working arrangements and is said to occur when a person has to carry out more than one role at the same time (Handy 1993.) Even if the expectations of each role are clear, one role may be in conflict with another. Role ambiguity and conflict impact on the extent to which effective collaborative working can be achieved. Reder and Duncan (1993) identify role confusion as one causal factor in communication breakdown and further suggest that as child protection involves so many workers, role differentiation and role complementarity can occur.

5.7 The emotional impact on professionals working in the area of safeguarding

Child protection work has always been subject to intensive scrutiny and recent high profile inquiries have served to underline the gravity of personal and professional practice and to highlight the stresses involved in this area of practice. Research undertaken in recent years has considered the impact of child protection work and has found that professionals working in this field exhibit high rates of stress and burnout (Bennett et al 2005). The destructiveness of excessive occupational stress is well recognised. It is important for service managers and leaders to recognise the emotional impact of safeguarding children work on professionals, and acknowledge that, despite the challenge in achieving collaborative working, it can have the positive impact of reducing such emotional stress.

Stress, according to Stokes and Kite (2001), can be defined as an agent, circumstance, and situation or variable that disturbs the normal functioning of the individual. It exists as a state when there is a discrepancy between the perceived

demands on an individual and their perceived or felt ability to cope. Stress cannot be objectively defined, as what one person defines as stress, another may define as challenge or excitement. Stresses in staff working in safeguarding roles can arise from several sources. These will find expression in professional interrelationships, in some circumstances being supported by them and in others exacerbated by these interactions and relationships.

Paton and Violanti (1996) describe organisations that are unique in that the employees risk exposure to traumatic events. Professional roles in such organisations are described as critical occupations. The description of such occupations' incorporates the recognition that, in the course of their duty, these professionals can encounter traumatic events which may, under certain circumstances, exert critical impact on their psychological well being.

Clarke (2008) describes a number of risks in critical occupations:

- The risk of exposure to events that are potentially traumatic
- Traumatic responding by an individual worker
- Organisational practices
- Events significant to the individual

Early work that looked at critical occupations often focused on workers in roles such as emergency services (Cooper 1997); however, more recently, it has been recognised that roles that involve more chronic exposure also meet the criteria for inclusion as "critical occupations." Working in the field of safeguarding children with daily exposure to the range of situations including abused children, hostile families, child deaths, threats of violence and interrogative and blaming media is now recognised as warranting inclusion in this category (Conrad and Kellar-Guenther 2006). This emphasises the need for workforce development processes as well as recruitment initiatives to address the issue as to date there is limited evidence that organisations have sufficiently taken account of this issue in ensuring their workers are adequately supported as being in a critical occupation.

A number of key professionals working with children in need and children in need of protection and their families work in community settings, which results in them working in relative isolation. This may increase vulnerability and act as a catalyst

to stress and burnout and seriously compromise the emotional well being of the practitioner.

Maslach et al (2001) define burnout in terms of three dimensions, emotional exhaustion, depersonalisation, and reduced personal accomplishment. Burnout is a response to the work context and Maslach et al (2001) in their research found the following factors to be important:

- Feeling that there is too much work to do within the time available
- Experiencing the conflict of having to meet competing demands
- Role ambiguity
- Lack of social support, especially from supervisors.
- Working intensively with people in either a care giving or teaching role.

The factors found in the research are particularly relevant to professionals working in the field of safeguarding.

The factors that predispose to burnout (Maslach 2001) are evident in a study undertaken following the 2009, Laming report (Holmes et al 2010). The research undertaken by Holmes et al, a survey, was distributed to 46 local authorities, with in-depth work undertaken with nine authorities. The research looked at the cost and capacity issues for local authorities in implementing the Laming report. Findings from the research include: 63% of social workers having seen an increase in caseloads over the last six months; 65% of councils report vacancies on intake and referral teams, with one third covered by agency staff; About three quarters of an average working week for social workers is taken up with paperwork; Social workers receive, on average, seven training days in a year. Supervision sessions are focused on case planning rather than challenges of practice, professional development and welfare needs. It is widely acknowledged that work related stress can lead to high sickness rates and high staff turnover, which in turn increases pressure on fellow team members.

5.8 Stress in inter-professional relationships and its impact on collaborative working

Stress and anxiety and defences are in themselves neither healthy nor unhealthy. Anxiety is inseparable from the human condition and exposure to anxiety is necessary for all individuals to allow the development of psychological defence structures to deal with it, in order to protect their mental health. Mental ill health results when defensive structures break down.

In considering burnout as defined by Maslach et al (2001), it is clear that this impacts on the functioning of the individual and on their ability to work collaboratively with others. Exhaustion which is a dimension of burnout prompts individuals to distance themselves from their work both emotionally and cognitively. Depersonalisation is an attempt to place distance between oneself and the service user in order to make work demands more manageable; this, however, can lead to poor assessment practice, a key multi-agency requirement in safeguarding practice (Rumgay and Munro 2001). In the field of safeguarding this increases risk to both individual clients and practitioners and indeed the organisation.

Mayhall and Norgard (1983) highlight the problem of child abuse and the varied reactions it evokes amongst professionals who are exposed to it through their professional roles. They suggest that, for some professionals, it evokes reactions that result in intrinsic barriers to coordination. This presents as conflict within teams, both single agency and multi-agency, resulting from other members' denial of suspicion which may be dealt with by projections or further denials. The denial may result for a number of reasons and may be multifaceted.

Much of the research undertaken studying the emotional impact of safeguarding children work on professionals has been undertaken in America and Canada.
Anderson (2000) undertook research to consider how child protection workers that had been working in this area of practice for two or more years coped with the stress of the job and the range of coping strategies used. The method used was cross sectional self reporting. The purposive sample consisted of 151 front line workers. The findings revealed that 62% scored in the high range for exhaustion.

In assessing the relevance of research from an international perspective, cultural components need to be considered; however, Munro (2002) states that research has found that individual characteristics have some significance but are less important than situational factors in producing burnout.

Bennett et al (2005) undertook research in Canada which aimed to measure the prevalence of burnout, psychological morbidity, job satisfaction and consideration of alternative work amongst multidisciplinary hospital-based child and youth protection professionals. The method they used was a postal survey, with the sample drawn from current and former members of all Canadian academic hospital-based child and youth protection professionals. There was a high response rate, 76.4% of current members and 92.9% of former members. Over one third (34%) of respondents exhibited burnout and 26.2% reported that they found the job extremely or quite stressful. Despite these findings, 68.8% reported high levels of job satisfaction.

Due to the nature of safeguarding work and the need for an experienced, competent workforce, the impact of work-related stress on collaborative working cannot be underestimated. At one level, there is the impact on the performance of the individual worker in terms of their own practice and their ability to function within a multi-agency team. Wenger (1998) identifies the importance of professionals' construction of their own identity; whereas Frost and Robinson (2007) identified that there are challenges for professionals to develop new sets of knowledge, identity and role as they move to more integrated working. In addition to this is the impact that stress may have on the retention of experienced staff. Gibbs (2001) considered factors that contributed to staff retention and reasons found included having a sense of mission, supportive supervision, peer support and work-family balance. In contrast, reasons related to staff leaving included: poor supervision, working conditions, stress and burnout.

Morrison (2007) considers the role of emotional intelligence in social work practice. Whilst the empirical evidence supporting the existence of a separate and measurable emotional intelligence is ambiguous, the role of emotion in the organisation of human behaviour is more firmly established. Morrison (2007)

examined the role of emotional intelligence in relation to the social worker's role with service users but also highlighted its significance in the areas of collaboration, cooperation and the way practitioners deal with stress. He argues that in the ever changing world experienced by social workers, it requires capacity to address both one's own emotions as well as those of others effectively.

On occasion, a child death due to abuse reaches the media spotlight which, in turn, can ignite public hysteria at the shock that professionals could allow the death to occur. At these times some parts of the media have a tendency to name and shame the professionals involved, usually social workers and health workers. In particular, with regard to the effect on social work as a profession, these occasions result in a severe shortage of willing and suitably qualified workers to take on child protection.

5.9 Collaborative work as a relief of stress

Collaborative working has been viewed by some authors to have the potential to reduce the emotional impact of the work they undertake. Drews (1980) and Fryer et al (1988) found in their research that various forms of peer support helped alleviate stress. This was also similar to the findings of Dale et al (1986) who suggest that the intensity of team dynamics stimulates intellectual and therapeutic creativity. The study undertaken by Carpenter et al (2003) does not reflect the same positive outcome of collaborative working in relation to the mental health of professionals. Carpenter's research focused on the impact on staff of providing integrated care in multidisciplinary teams in the North of England. Interestingly, the degree of service integration did not appear to have much bearing on job satisfaction or levels of work-related stress suffered by professionals.

5.10 Developing professional resilience

Until recently, research into the psychological impact of traumatic events both at the personal and professional level has tended to focus almost exclusively on the potential for negative outcomes, with no consideration of the potential for positive aspects. This approach is also evident in the nature of psychometric instruments and surveys employed to assess impact (Maslach and Jackson 1986, Pearlman 1996a, Pearlman 1996b).

There is also insufficient empirical evidence as to why some staff exposed to certain work experiences exhibit higher degrees of stress than others exposed to the same circumstances. A number of researchers have studied the notion of resilience. A number of studies relate to children and young people who have experienced abuse and neglectful parenting. More recently, some researchers have considered resilience in relation to workers working in critical occupations. Garmezy (1983) identified individual characteristics of resilience, which includes a wide array of social skills, positive peer interactions, a high degree of social responsiveness and sensitivity, empathy, a sense of humour, high degrees of cooperation, participation and critical problem-solving skills. It appears from the literature on resilience (Rutter 1987, Gilligan 2001) that it is a combination of personal and the professional context within which professionals experience their working life that fosters or inhibits the latent or manifest qualities of resilience. Resilience therefore should be viewed not as a fixed attribute, but as vulnerabilities or protective factors that modify the individual's response to risk situations and operate at different points in the professional's working life. Protective factors mediate between risks and the resilience the individual seeks.

"Protection does not reside in the psychological chemistry of the moment but in ways in which people deal with life changes and in what they do about their stressful or disadvantageous circumstances. Particular attention needs to be paid to the mechanisms operating at key turning points in people's lives when a risk trajectory may be redirected onto a more adaptive path".
(Rutter 1987:329)

Because resilience is a dynamic process, managers and supervisors within organisations with a responsibility to provide services to safeguard children need to focus on strengthening protective factors such as supervision to support professionals to develop resilience when faced with the external risks such as hostile and aggressive clients, complex caseloads, child deaths and adverse press.
Rutter (1987) identifies four major protective processes that foster resilience:

- Reducing negative outcomes by altering the risk or exposure to risk
- Reducing negative chain reaction following risk exposure

- Establishing and maintaining self esteem and self efficacy
- Opening up opportunities.

Although in the area of work that aims to safeguard children it is not possible to eradicate a number of the negative factors, by focusing upon the development of protective factors, a more favourable balance in the professional's life may be achieved.

5.11 Supervision

Individual support, safety and organisational governance are vital elements in organisations that have responsibility for staff working in the very challenging area of practice that aims to safeguard children and young people. Supervision is one of a range of solutions to ensure professionals receive support when practising in an area that poses such challenges. Supervision has different meanings for different individuals, agencies and professional groups and Lister and Crisp (2005), in their study of supervision within health settings, identified a range of supervision practices across NHS Trusts. Lister and Crisp, in their research did, however identify that within community nursing there was evidence of the increasing acceptance of the importance of supervision. Supervision may be described according to its main emphasis, and clinical supervision is a broader concept than safeguarding supervision, although the skills required by supervisors are similar.

Clinical supervision is described by Faugier and Butterworth (1994) as a process for promoting personal and professional development that should take place within a supportive framework. safeguarding supervision moves beyond this definition by ensuring safe outcomes for the child and young person by close reflection on the case. Proctor (1986) describes three main functions of supervision; formative, restorative and normative. They encompass the educational, supportive and qualitative functions of the supervisory relationship. Although a number of inquiries into the deaths of children (London Borough of Brent, 1985, London Borough of Greenwich, 1987, Laming Inquiry, 2003) have stressed the need for adequate safeguarding supervision of practitioners, it may be viewed that these have served to erode the restorative function at the expense of managerial

approaches to supervision. An agency's failure to provide a work environment that supports good practice may result in staff burnout. Guidance at government level clearly states that supervision should be available to front line workers:

"Supervision should include scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner, and providing coaching, development, and pastoral support. Supervisors should be available to practitioners as an important source of advice and expertise."

(Department of Health 1999:109)

Agencies have tended to focus on the issues of accountability, evidenced by the increase of policies and procedures as the main response to evidence that workers receive insufficient and poor quality supervision. This fails to address the need for emotional support by the practitioner.

The importance of supervision for staff working in safeguarding is clearly expressed by Morrison (1990) who states that child protection work can arouse powerful feelings in staff, which has the potential to affect their rationality. The importance of skilled supervision which places particular emphasis on addressing the professional stress and anxiety arising from safeguarding work is acknowledged by a number of authors (Richards et al 1990, Jones et al 1991, Gibbs 2001).

Supervision skills are seen to be important to support the worker, and also to assess over time if role conflict, role ambiguity and aggression are affecting their safeguarding work. Supervision skills are also seen to be important in ensuring that the worker is not becoming potentially dangerous by putting themselves and/or the child (ren) at risk by avoiding, consciously or otherwise, the effect of parent service user threat in their work. The potential dangerousness of workers who are severely stressed and unsupported is noted by Dale et al (1986) and by Reder et al (1993).

It is not enough to have a model of safeguarding supervision in place. What is more important is that supervision provides practitioners with supportive challenge to their thinking and reasoning in relation to safeguarding children. Supervisors

need to be helped to develop and sustain their supervision practice. The organisation needs to provide clear expectations about levels of competence, appraisal and supervision for practitioners working at different levels and with varying degrees of exposure to safeguarding work. Supervision should provide a safe but challenging opportunity to oversee and review cases with an experienced supervisor, who acts as an objective, fresh pair of eyes, allowing a systematic guard against rigid adherence to a particular view. Laming (2003) recognised this need for a learning culture at all levels of the organisation, including the management level, which promotes an ethos in which reflective practice and self questioning is accepted and actively promoted. In safeguarding work, the risks associated with the area of work can result in avoidance of decision making or reluctant decision making, with decisions then being made at the point of crisis. Macdonald and Macdonald (2010) discuss risk and decision making in situations of uncertainty and argue for a move away from focusing practice around low probability, high outcome situations such as child deaths. Supervision is key in bringing about such change.

Dingwall et al (1983) identified three specific types of biases in child protection work. The first bias is the rule of optimism, i.e. looking for the most positive explanation for incidents that occur. The second bias described by Dingwall et al is natural love, i.e. the belief that parents invariably naturally love their children. The third type of bias is cultural relativism, where elastic norms and standards about the care of children and family life are applied and linked to perceived cultural differences. These biases in child protection work are challenged when organisations have robust safeguarding supervision processes in place. Dingwall et al (1995) recognise that such biases are operated at the level of the individual but that they do so as members of organisations, where structures, incentives and sanctions are designed to sustain the culture embedded within the organisation at that time. This is important when considering the roles and responsibilities of individual professionals in terms of how the actions of that individual may result in tensions within a multi-agency context.

As has already been discussed, child protection work inevitably involves front line practitioners working in unstable, distressing and sometimes personally

threatening situations. The importance of supervision in supporting staff in this environment cannot be over-emphasised and is supported by Reder and Duncan (1999), Schon (1983) and Holland (2004), who advocate a "reflective mind set". Such an approach to practice is essential to enable practitioners across agencies to make the best possible decisions, which in turn is supportive to the practitioner working in such a stressful area of practice. Reflective practice does, however, need to be supported at the level of the individual, the team and the agency, and requires careful planning, time and space in which to develop and be maintained.

Laming (2009) emphasises the vital importance of a supportive learning environment that actively encourages the continuous development of judgment and skills and reiterates the long accepted position that high quality supervision is critical to good practice. Brandon et al (2005), state that practitioners who are well-supported, receive supervision and have access to training are most likely to think clearly and exercise professional discretion. In practice, there is often a conflict between the functions of supervision, with managers focusing upon the managerial aspect, whereas practitioners express a need for time within the process to explore their thoughts and feelings. A recent survey demonstrated that practitioners' experience of supervision had worsened since the first Laming Inquiry, with an increasing emphasis on bureaucratic and managerial goals and meeting targets rather than encouraging analysis and reflective practice (Hunter 2009).This reinforces the need to move away from the traditional approach of undertaking serious case reviews to a systems approach as discussed in chapter 3, to ensure the lessons from the review are translated into practice change. Brandon et al (2008) recognise the importance of supervision in helping practitioners to think, to explain and to understand, but also in helping them to cope with the complex emotional demands of safeguarding work. Gibbs (2006) suggests that effective supervision that moves away from the management function to the supportive and reflective functions could contribute to lowering the high attrition rates amongst child protection workers. Supervision can also help the practitioner to understand the role of others and therefore promote effective collaborative working in safeguarding. Several authors have recognised the importance of supervision in supporting professionals (Richards et al 1990, Rushton and Nathan 1996, Littlechild 2003, Owen and Pritchard 1993). In the changing world of

safeguarding and the progression of collaborative working, the challenge to take forward is the consideration of the most appropriate model of supervision in the context of future multi-agency teams.

In this chapter, literature that relates to the concept of professional roles in relation to safeguarding children has been discussed, including those working at an operational level and those with strategic leadership roles. The roles of professionals who were included in the research, social workers, general practitioners, health visitors and school nurses were specifically considered and issues around conflict which may militate against collaborative working were explored. Stress, which, from the literature reviewed, is a well-documented outcome of safeguarding practice, has been discussed, and supervision, as a means of enhancing safeguarding practice as well as ensuring the individual practitioner is appropriately supported to undertake their safeguarding role effectively has been explored within this chapter. In Chapter 6, the two boroughs included in the research will be discussed.

CHAPTER 6
An Overview of the Two Boroughs

6.1 Introduction

Stage 2 of the research involved searching information in order to make a comparison of the two boroughs included in the research. This chapter will present the contextual data about the two research sites selected for the study. The study took place in two boroughs, referred to as borough 1 and borough 2 that are part of the Greater London Authority. The Greater London Authority consists of 32 London Borough Councils which have a similar status to the unitary authorities, although the Greater London Authority coordinates activities across the 32 boroughs. A unitary authority is a type of local authority that has a single tier and is responsible for all local government functions. Two tier authorities have functions devolved between county or shire councils and district, borough or city councils. Two research sites were selected, since this was the maximum considered feasible, given the size of the research project. The inclusion of two sites was thought likely to increase the robustness and significance of the findings (Sudman 1976). The decision to undertake the study across two boroughs enhanced the richness of the information gathered. It also gave the opportunity to make comparisons regarding the extent of effective collaborative working and allow consideration to be given to the factors that contributed to this.

The research sites were selected using certain criteria, including the need for the health and social care organisations to have coterminous boundaries, which, in itself, does not guarantee collaboration; However, their absence increases the challenge (Pugh-Thomas 1987). The other criterion for selection was the need for the two boroughs to have similar demography and levels of deprivation. The final decision to include the two sites was based on the fact that despite the two sites having similar demographic features and comparable levels of deprivation. The rates of child protection registration revealed marked differences at the time this study commenced. In examining local safeguarding policies, it was evident that although the child protection policies within the two boroughs were very similar,

there were marked differences in relation to multi agency practice for children in need within the two boroughs.

Although there is very little research available linking demographic factors and deprivation levels with rates of child abuse or children entering local authority care, the Audit Commission (1994) recommended that use should be made of the Office of Population, Censuses and Surveys (O.P.C.S) and other demographic data to build up a picture of the incidence of risk indicators in a local area. In reviewing the available literature, the work undertaken considering the links between demography, deprivation and child abuse was found to be somewhat sparse. Cycles of deprivation and neglect overlap. Issues such as chronic housing, poverty, unemployment and poor education all undermine resilience.

Sedlak and Broadhurst (1996) discuss the national incidence study of child abuse and neglect undertaken by the Department of Health and Human Sciences in Washington DC. This study is the most comprehensive federal source of information about the incidence of child maltreatment in the United States. The third national incidence study found that major contributory factors to child abuse and neglect include family structure and size, poverty and community violence. Children in single parent households were at higher risk of physical abuse and all types of neglect than were children in other family structures. It is important, however, to acknowledge that one cannot single out one individual factor as the cause of abuse and that more often abuse is the result of a combination of several factors. The study also found a correlation between family income and the incidence of child abuse and neglect. Although the reasons for this are not clear, one possible explanation is that the stress that results from financial hardship may in turn result in reduced tolerance levels and the use of inappropriate punishment by parents towards their children (English 1998). English further suggests that the effects of poverty, including the increased stress levels, result in an increase in other risk factors such as depression, substance and alcohol use and domestic abuse. These risk factors in turn increase the risk of child abuse and neglect. This theory is supported by the National Centre for Child Poverty (2004), whose research showed a higher prevalence of depression, substance abuse and domestic abuse in low income families. This same theory could be applied to the correlation

between unemployment and the higher incidence of child abuse and neglect, with unemployment often resulting in less disposable income and potentially increased stress.

Bebbington and Miles (1989) undertook research which replicated earlier research undertaken by Packman in 1962 and 1968. The research investigated the family background of 2,500 children admitted into care throughout England. Although not all children taken into care will have had experience of the child protection system, it is well recognised that children in the care system are a sub group of Children in need. In Bebbington and Miles's research, comparisons were made between children admitted into care with those children who were not in care, in order to identify factors that increase the likelihood of a child entering the care system. Fourteen relevant factors were identified, with single parenthood being the most significant, increasing the chances of a child entering the care system by eight times. The authors did not give consideration to operational factors that may have influenced care entry. However, they controlled for this by including several authorities within the study.

The communities and neighbourhoods in which families live can have a major influence on the child's development and the adult carer's ability to parent. Rutter (1984) undertook research that concluded that the stresses of inner city life were found to be the cause of a catalogue of family problems, which in turn produced negative consequences for the child. Colton et al (1995) found marked geographical variations in rates of child abuse. The variations could be explained in part by the socio-economic and demographic composition of different communities.

In considering socio-economic data, income distribution across different areas of the country varies enormously. The present level of income inequality across the country is concerning. Families with children are particularly vulnerable. Goodman et al (1997) and HM Treasury (2008) estimate that as many as twenty-five percent of children in Britain experience a state of permanent poverty. The families most at risk are lone parent families, families of minority ethnic origin and two parent families with neither adult in employment (Platt and Noble 1999; Smaje

1995). Garbarino and Kostelny (1992) accounted for nearly four-fifths of the variation in child maltreatment among different areas in Chicago by the measures which included poverty, unemployment, family structure (ratio of children to adults and percentage of female headed households), overcrowding, ethnic origin, educational level and stability of residence.

A number of the measures identified by Garbarino and Kostelny in their study were considered in relation to the two boroughs included in this study in order to identify variations. The data presented that relates to the two boroughs is dated, but was relevant at the time the research began.

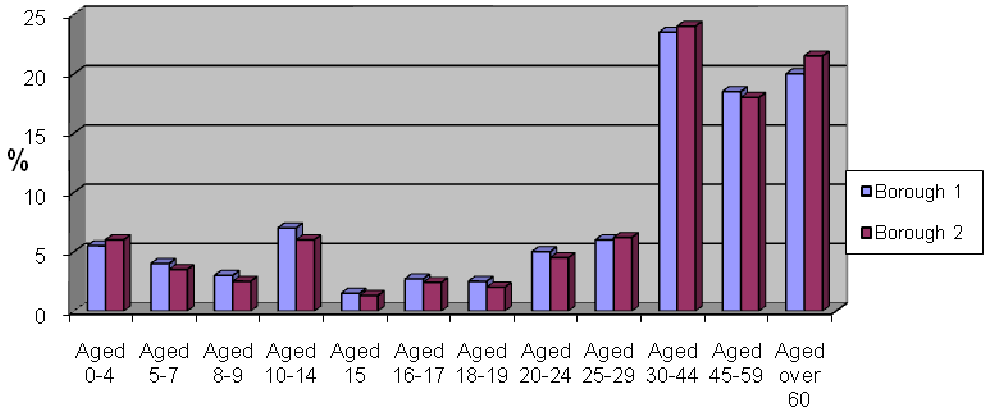
6.2 Resident population within the two boroughs

The resident population of borough 1 as measured in the 2001 Census was 218,307 of which forty-eight percent were male and fifty-two percent female – of the 218,307, twenty-one percent were aged below sixteen years.

The resident population of borough 2 as measured in the 2001 Census was 295,532 of which, as in borough 1, forty-eight percent were male and fifty-two percent female. In borough 2, a similar percentage, twenty percent of the resident population were aged below sixteen years.

The age breakdown of the population of both boroughs is illustrated in Figure 6.1.

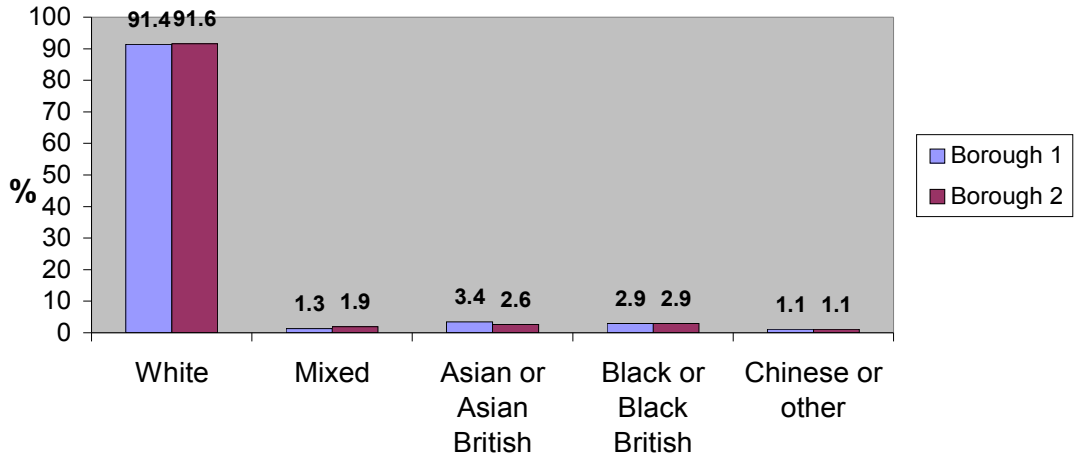
Figure 6.1 - Age breakdown for boroughs 1 and 2 in 2001
Source: Office of National Statistics 2001



Different demographic structures, cultural traditions and economic characteristics of various ethnic groups underlie distinctive patterns of family size and household composition. Asian households tend to be larger than those from other ethnic groups (Office for National Statistics 2002).

Within both boroughs 1 and 2 over 90 per cent of the population are white. The ethnic structure of the two boroughs is shown in Figure 6

Figure 6.2 - Ethnic structure of borough 1 and 2 in 2001



In 2002 more than half of families in the UK, with dependent children headed by a person of mixed racial origin or Black Caribbean, were lone parent families. The Department for Work and Pensions (2001) undertook a survey that considered income. Within the survey, "low-income household" is defined as a household having less than sixty percent of the median equivalised disposable income. Equivalised income is household income which is adjusted by using an equivalence scale to take into account the size and composition of the household. Disposable income is defined as the total income from wages and salaries, self-employment and social security benefits minus deductions for income tax, local taxes and pension and national insurance contributions. Thus it is the amount individuals or families have available to spend or save. Low income is used as a proxy for poverty.

Poverty measures have often been divided into two broad types, direct and indirect measures (Hallerod 1995). An indirect measure uses income, however income cut offs used to define poverty are often viewed as arbitrary. A direct measure considers outcomes such as the living standard people actually enjoy. A number of authors have supported the use of direct measures as a more accurate assessment of what it really means to be poor (Perry 2000, Nolan and Whelan 2005). More recent U.K. child poverty targets also use information on material possessions as well as

low income. The survey undertaken by the Department for Work and Pensions (2001) found that people from minority ethnic groups were more likely than white people to live in low-income households.

6.3 Degree of deprivation within the two boroughs

Deprivation is commonly measured using the Jarman Under-privileged Area (UPA) Score (Jarman Index 1991). The Jarman index was introduced in 1983 in an attempt to identify under privileged areas for the purpose of health care planning. It was constructed from the responses of general practitioners to a question asking how much they thought each of thirteen given factors increased their workload. Although the Jarman Index is widely used, Smith (1991) states there is lack of evidence that general practitioner workload is related to Under- privileged area scores. Eight factors which are available from census data are now generally included in the index. The Jarman Under-privileged Area Score is calculated using the eight variables from the Census, to give each area a score relative to the England and Wales average of 0. Areas with a UPA score greater than 0 are deemed to be more deprived. The eight variables used are

- Elderly living alone
- Children aged under 5
- Residents in 'lone parent' households.
- Residents in households with a head of household in the unskilled socio-economic group.
- Unemployed as a percentage of economically active.
- Residents in overcrowded households (more than one person per room).
- Residents who changed address in the previous year as a percentage of total residents.
- Residents in households headed by a person born in the New Commonwealth.

In 2000 borough 1 had a UPA score of –3.50 and borough 2 –10.83 (Department of Health 2000a). Nationally, scores range from -50 to 70 and therefore in terms of overall deprivation, both boroughs are deemed to be more affluent than the national average.

The Acheson Report (1998) highlighted the importance of maternal and early child health as a means to reduce inequality. There is a growing body of literature on the

theme of health inequality and how to measure it, but there is often a lack of clarity in terms of appropriate responses. Reduction in inequality is at the heart of government policy and in practice the term is frequently used for both health and social inequalities.

The use of the Jarman Index for measuring deprivation was reviewed and in terms of the annual returns that councils are required to make to the Department of Health, was superseded by the index of local deprivation (1998). This combines indicators on the following topics: total unemployment, male long term unemployment rate, Income Support recipients, non-Income Support recipients receiving council tax benefit, dependent children of Income Support recipients, standardised mortality rate, low educational (GSCE) attainment, percent of seventeen year olds no longer in full time education, derelict land, home insurance weighting, households lacking basic amenities, plus all households in non-permanent accommodation and overcrowded households.

In 1998/99, borough 1 had a score of 3.74, the third largest in its comparator group and borough 2 5.27, the fifth largest in its comparator group indicating them to be relatively affluent boroughs. Comparator groups are groups of local authorities whose socio-economic profiles are determined by national criteria and are grouped together for comparison purposes. Although borough 1 and 2 were in different comparator groups, this may be due to the large number of local authorities, resulting in authorities with minor variations being placed in different comparator groups.

This again was reviewed and was superseded by the Indices of Deprivation (DETR 2000). The recurrent reviewing and change in the approach to measuring levels of deprivation, with each indices using a range of different criteria, makes meaningful comparison and assessment of trends challenging. This indices of Deprivation (DETR 2000) is based on thirty-three indicators, categorised into six domains:

- **Income deprivation** – the number of people on a low income.
- **Employment deprivation** – the number of people who want to work but are unable to do so through unemployment, sickness or disability.
- **Health deprivation and disability** – the number of people whose quality of life is impaired by poor health or disability.

- **Education skills and training deprivation** – the lack of qualifications amongst adults and children of different ages.
- **Housing deprivation** – the number of people living in unsatisfactory housing and, in the extreme case, homelessness.
- **Geographical access to services** – the number of people lacking access to essential services.

Each domain is weighted. The highest score indicates the highest level of deprivation and the lowest the lowest level. Currently, Ofsted provide a statistical neighbour model based on census data and the Institute of Public Finance comparator councils provide a model based on deprivation and demography data. But there is now a need for a new model based on the five Every Child Matters (ECM) outcomes, which embraces the key elements of the existing models and provides local authorities and their partner agencies with a tool for assessing and comparing their performance with their statistical neighbours. Ideally, this new model would supersede the existing models within the context of children's services and provide a single starting point for benchmarking performance.

Using the Indices of Deprivation (DETR 2000) in 2000, borough 2 was the third most affluent borough in its comparator group and borough 1 the fifth most affluent. In comparing the range of data reviewed in relation to borough 1 and 2 to contextualise the two research sites, a number of similarities were found.

One of the indicators used is the percentage of dependent children living in households with non-earning adults. In 1999/2000 in borough 1, there were 12.68% of dependent children living in households with non-earning adults compared to 11.99% in borough 2.

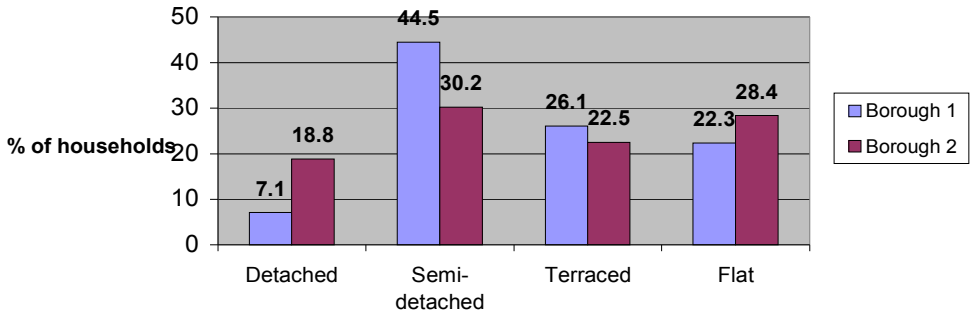
Earlier in the study, it was highlighted that a major contributory factor to low income and therefore one of the indicators used to measure levels of deprivation, is the percentage of children living in families headed by a single adult. In 1999/2000, there were 13.61% of dependent children under 18 years of age living in lone parent family households compared to 13.72% in borough 2.
In 1999/2000 the number of employment deprived in borough 1 was 9,359, compared to 11,275 in borough 2.

In 2000/2001 there were 183 children per 1000 population under 16 years of age living in families where adult members are in receipt of Income Support or Job Seekers allowance in borough 1 and 147 in borough 2.

6.4 Housing

The association between housing and health have been well documented (Kawachi and Berkman 2003). Hiscock et al (2000) considered the effects of home ownership and health, and reported the benefits of security and control experienced as a result of home ownership. The various types of housing in which residents within the two boroughs live are illustrated in Figure 6.3.

Figure 6.3 – Housing within the two boroughs



Source: Office for National Statistics 2001

Within borough 1 in 2001, seventy-nine percent of households were living in owner-occupied accommodation and fourteen percent in social rented housing (renting from council, a housing association or a registered social landlord), with the remaining seven percent living in privately rented accommodation or living rent free. In borough 2 in 2001, seventy-six percent of households lived in owner-occupied accommodation, fourteen percent in social rented housing and ten percent in privately rented or rent-free.

In borough 1, the proportion of one-person households in 2001 was twenty-nine percent, in borough 2, thirty-one percent and in England and Wales thirty percent (Office for National Statistics 2001).

Although owner-occupation is prevalent in both boroughs, which suggests an affluent population, this is not necessarily a reflection of disposable income which could be a more accurate predictor as to whether or not there is financial stress.

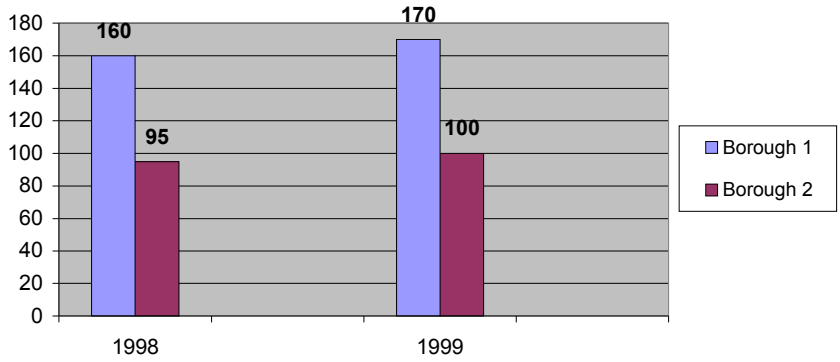
In considering the percentage of dependent children living in overcrowded accommodation in 1999/2000 borough 2 had 6.22% and in their comparator group had the lowest percentage. Borough 1 had 7.86%, which in their comparator group was the third lowest.

6.5 Child protection activity

The current research project aimed to compare collaborative working in safeguarding children between two boroughs. Having considered demographic data and data that is indicative of deprivation; data around safeguarding activity will now be presented.

At the time of commencement of the study, the child protection register was in existence. At this time, the child protection registration rate (the number of children placed on the child protection register per 10,000 children) in borough 1 was significantly above the national average whereas the rate for borough 2 was below (see Figure 6.4). In 1998 in England, 30,000 children (27 per 10,000) had their name added to the child protection register. In borough 1 in 1998, the registration rate was 32 per 10,000 children, whereas in borough 2 the rate was 15 per 10,000 children. In 1999, in England 30,100 children (27 per 10,000) had their name added to the child protection register. In borough 1 in 1999, the registration rate was 33 per 10,000 children, whereas in borough 2 the rate was 16 per 10,000 children.

Figure 6.4 – Registrations on child protection registers



Source: Department of Health 2002a

More recent registration rates show a very different picture. In 2005 in England 30,700 children (28 per 10,000) had their name added to the child protection register. In borough 1 in 2005 the registration rate had fallen to 25 per 10,000 children, whereas in borough 2 the rate was 19 per 10,000 children. Although borough 2 continues to exhibit lower rates of child protection registrations, both boroughs at this time were below national average. In the period between 1998 and 2005, the Laming Inquiry had placed safeguarding high on the government's agenda and there was wider recognition of the need to provide services at an earlier stage before the threshold of significant harm was reached. Hence it is possible that this may have had some impact on registration rates. In the period 2007 to 2008, the picture between the two boroughs continued to change, with borough 1 having a rate of 12 per 10000 children subject to a child protection plan and borough 2 a rate of 21 per 10000. Over a 10 year period, although borough 2 has shown an increase in rate of 6 per 10 000 children, borough 1 has seen a dramatic decrease of 20 per 10 000. There is no clear explanation for the changes but one possible contributory factor is the different rate of progress in implementing the Common Assessment Framework discussed in more detail in chapter 2. Another possible contributory factor could be the application of thresholds, which is addressed more comprehensively in chapter 4.

Child protection registrations, however, only provide a snapshot, and it is important to consider the range of child protection activities. In terms of the number of referrals of children and young people to social services departments there are differences between the two boroughs as can be seen in Table 6.1.

Table 6.1 - Referrals of children and young people to social services departments during the year ending 31st March 2005

	All referrals number/rate	**Referrals within 12 months of a previous referral number/rate**
Borough 1	3930 (769 per 10,000 children)	670 (131 per 10,000 children)
Borough 2	2685 (406 per 10,000 children)	375 (56 per 10,000 children)

Source: Department for children schools and families 2006.

The statistics available for referrals to social services departments for children and young people demonstrate that in there were significantly less referrals made in borough 2 in comparison to borough 1. Although the rates of referral in 2008 show only minor changes in rate, it is significant that referrals for borough 1 remain constantly higher than both the national rate and those of their statistical neighbours. In interpreting the statistics, there needs to be caution regarding the accuracy of the systems and the human element inputting the data.

In examining the figures that demonstrate the numbers of referrals that lead to an initial assessment in Table 6.2, a different picture presents, with a considerably higher proportion of referrals leading to an initial assessment in borough 2 compared to borough 1. Again, this needs to be viewed with caution, as it is dependent on the interpretation of what a referral is and the threshold applied.

Table 6.2 - Initial assessments of children and young people completed during the year ending 31st March 2005

	All initial assessments number/rate	All initial assessments as a % of total referrals in the year
Borough 1	1495 (292 per10,000 children)	38%
Borough 2	1610 (243 per 10,000 children)	60%

Source: Department for Children, Schools and Families 2006.

Table 6.3 provides the information available in terms of the number of children in both boroughs who were subject to section 47 investigations and the subject of initial child protection conferences. The rates of both section 47 enquiries and initial child protection conferences were higher in borough 1 compared to the rates in borough 2.

Table 6.3 - Section 47 enquiries and initial child protection conferences during the year ending 31st March 2005

	All children who were subject to section 47 enquiries which started in the year number/rate	Children who were subject of an initial child protection conferences number/rate
Borough 1	335(65 per 10,000 children)	150 (29 per 10,000 children)
Borough 2	240 (36 per 10,000 children)	160 (24 per 10,000 children)

Source: Department for Children, Schools and Families 2006.

In considering data from the above tables it is clear that in borough 1 there are higher rates of referrals and re-referrals of children and young people to social services departments but lower rates of initial assessments than borough 2. The rates of section 47 enquiries, initial child protection conferences and children whose name were placed on the child protection register, up until 2005, were higher in borough 1 in comparison to borough 2. However, after 2005 there seems to have been a shift in some of the rates, most significantly the rate of children subject to a child protection plan was dramatically reduced in borough 1 whilst rising in borough 2. It is difficult to conclude with any certainty the reasons for these differences and, in order to gain clarity a focused research study would need

to be commissioned addressing thresholds at the levels of children with additional need, children in need of services and children in need of protection.

6.6 Looked after children

In 2000/2001 in borough 1 there were 4.0 children per 1000 population aged under 18 years who were looked after. This compared to 4.4 per 1000 population in borough 2. These figures remained similar over time, with 4.0 children per 1000 population being looked after in borough 1 at the end of 2004 compared to 4.7 in borough 2.

In borough 1, 71.45% of children aged above four years remained in foster placement longer than two years, compared to 43.06% in borough 2. For young people who were leaving care at 16+ years in borough 1, 29.73% had achieved 1 GCSE Grade A-G or GNVQ qualification compared to 40.54% in borough 2.

6.7 Expenditure on children and their families

In terms of government allocation of funding, this was achieved at the time the study began, using a formula referred to as the Standard Spending Assessment (SSA) which is based on relative need of areas. This can then be topped up by local authorities from council tax. Its limitations have been recognised in terms of the fact that it cannot take account of pressures that are unique to individual authorities. In terms of the percentage of expenditure on children and families, borough 1 spent 19.3% and borough 2 18.4% at the time the study commenced.

6.8 Policies and Procedures

The two boroughs at the time the study commenced had in place child protection policies, procedures and guidelines. Borough 1 and 2 were members of Area Child Protection Committees, and staff were expected to base their child protection practice on the multi agency child protection procedures developed by those two Area Child Protection Committees. Both boroughs had in place single agency child protection procedures and guidelines which complemented the policies developed by the Area Child Protection Committees. The two sets of single agency procedures and guidelines were different in their style but broadly reflected the Working Together Document (Department of Health 1999). At the

time the final stage of the research was undertaken, the pan London Safeguarding children procedures were in use by both boroughs 1 and 2.

Although approaches to protecting children once the section 47 threshold had been reached were broadly the same in both boroughs, the approach adopted for children in need as defined in section 17 of the Children Act 1989 were different between the two boroughs. Borough 1 at the time the study commenced did not have formal multi agency approaches in place to support children in need and their families, whereas borough 2 had child in need procedures on which multi agency practice was based. The outcome of this was that if a child in need lived in borough 2, there was a multi agency response in terms of assessment, planning and intervention to respond to the need. This process was overseen through multi agency meetings, which reflected the approach used for children in need of protection, and resulted in earlier intervention. It is possible that this multi agency early intervention contributed to the lower child protection registration rates. During the time the study was in progress, the introduction of the common assessment framework, resulting in intervention at an even earlier stage, may have contributed to the marked change in numbers of children reaching the threshold of child protection plan.

This chapter has compared a number of factors between borough 1 and borough 2 that reflect the demographic and deprivation levels within the two research sites. Research has shown that the communities and neighbourhoods in which families live can have a major influence on the child's development and the adult carer's ability to parent (Rutter 1984). The data presented has also made reference to how this compares to the borough's statistical neighbours. Statistical neighbour models provide one method for different areas to benchmark progress. For each local authority, these models designate a number of other local authorities deemed to have similar characteristics. Any local authority may compare its performance (as measured by various indicators) against its statistical neighbours to provide an initial guide as to whether their performance is above or below the level that might be expected. In comparing available data for the two boroughs both in terms of deprivation and demography, the two boroughs were found to be very similar, however an important difference in terms of the current research was that at a local

policy level. Borough 2 had well developed child in need policies at the time the research commenced, which was not the case for borough 1. At the time the research commenced the child protection registration rate (the number of children placed on the child protection register per 10,000 children) in borough 1 was significantly above the national average whereas the rate for borough 2 was below. Although the focus of the current research is collaborative working, it is important to consider the effects of policy both locally and nationally and although the current research could not conclusively demonstrate whether the implementation of child in need policies resulted in a reduction of children becoming subject to a child protection plan, it is an important consideration. Chapter 7 will describe the research design and methods used for the current research.

CHAPTER 7
Research Design and Methodology

7.1 Introduction

The purpose of this chapter is to describe and discuss the research design and methodological considerations and give a detailed account of the process followed for the study. The chapter will begin with examining the principles and theoretical perspectives underpinning the research design and approach, and will consider methodological rigour and ethical considerations. The strategies used for data collection, organisation and analysis will be discussed.

The focus of the research is the exploration of the perceptions of both health and social service professionals on the extent to which a collaborative approach is adopted when working with families where there are children in need of services or children in need of protection. In order to explore this area, a suitable methodology needed to be selected to gain insight into the participants' perceptions and to identify factors that enhanced or inhibited collaborative working from the perspective of participants.

7.2 Research paradigms

Numerous studies have considered the range of approaches to inquiry used to answer research questions. Maxwell (2005) defines a paradigm as a set of very general Philosophical assumptions about the nature of the world (ontology) and how we can understand it (epistemology), assumptions that tend to be shared by researchers working in a particular field. The principles and theoretical perspectives underlying research can be traced to two basic paradigms, quantitative and qualitative methodologies. There have been ongoing debates between the different schools of social sciences and their respective uses have been distinguished from one another through their basic suppositions.

Gerrish and Lacey (2010) assert that a notable difference between the two paradigms is the focus of their analysis and the assumptions associated with each paradigm. Gerrish and Lacey (2010) clarify this, stating that whilst quantitative research focuses primarily on numbers, qualitative research concentrates on words.

This may be an over simplification and Duffy (1985) explains that quantitative methods have often been associated with the aim of identifying and explaining causal relationships between variables and events. In contrast, qualitative methodologies derived from philosophies within social and behavioural human sciences, known as naturalist inquiry, do not seek to provide primarily quantitative answers (Pope and Mays 1995). The naturalist inquiry therefore allows the investigator to be open to all elements of the situation (Lincoln and Guba 1985). It may be argued that a focus on numbers when the subject matter of the research is the actions of human beings is too limiting, and it may be more meaningful to focus on the motivation that people have for certain actions. The naturalist approach has no hypothesis, and concepts and theories are developed from the data, with the focus on lived experiences, interpretations and the meaning people attach to events or situations. Qualitative methodologies aim to describe and understand the meanings of individuals' experiences or particular events within the natural settings, based on the belief that behaviour can be understood in the context in which it occurs (Lincoln and Guba 1985).

The rigid differentiation between qualitative and quantitative approaches as opposing traditions does not encourage interaction between the two camps, but instead researchers on either side become entrenched and often fail to recognise the benefits of each other's work (Pope et al 2007). The view that quantitative methods aim for reliability through the use of tools, whilst qualitative methods aim for stability by understanding how people really behave and what people mean when they describe their experiences, attitudes and behaviours is strongly supported by Pope and Mays (1995). It can therefore be argued that qualitative and quantitative processes complement rather than oppose each other.

Gephart (1999) discusses the rivalry amongst research paradigms and analyses the alternative philosophical paradigms of positivistic, interpretive and critical science research. Positivism assumes the world is objective; therefore positivist researchers generally seek out facts in terms of relationships between variables. The positivist view is therefore developed from theories and concepts established before the study begins and does not address the subject's experiences and interpretations nor the context of the research. Interpretive research is concerned

with meaning; interpretive researchers assume that knowledge and meaning are individual interpretations. The focus is upon subjective meaning as to how individuals apprehend, understand and make sense of events. This is a combination of critical theory and postmodernism and can take many forms including historical essays, field research and case studies (Boje, Gephart and Thatchenkery 1996).

The positivistic paradigm has been challenged in terms of the limitations of quantitative methods (Ghoshal 2005), and the relevance of the interpretive paradigm is recognised as offering ways to understand research participants' own meanings in relation to an area of study. In this research study, a combination of both qualitative and quantitative approaches were used, an approach advocated by Schram and Caterino (2006), who had cautioned about restrictive and prescriptive approaches and their exclusivity. Holloway and Wheeler (1996) also suggested that methodological processes and strategies involve breaking the rules and guidelines of specific approaches and support the eclectic approach to data collection and analysis used in this study.

Porter (1996) suggests that qualitative research is not primarily concerned with the identification and explanation of facts but with people's interpretation of those facts. Fossey et al (2002) state the aim of qualitative research is to address questions concerned with developing an understanding of the meaning and experience dimensions of human's lives and social worlds. It explores and understands people's experiences, feelings and beliefs, and central to this approach is whether the research participants' subjective meanings, actions and social contexts, as understood by them, are illuminated. This is highly relevant when exploring the perceptions of professionals who are working in the field of child protection, as it places value on that experience and offers valuable insight into situations in which various professional groups are required to work together.

A qualitative approach to research has a number of key characteristics. Burns and Groves (2003) explain that the specific philosophical orientations differ with each approach and that they direct the methodology. In accepting that each qualitative approach is unique there are however several commonalities.

Key characteristics of the qualitative approach include:

- The emic perspective: the desire to see through the eyes of those under study.
- The relationship between researcher and subject. In order to see through the eyes of those under study, the researcher usually works closely with those under study.
- The nature of the data. Qualitative data uses the words and behaviour of the participants, usually gained through interviews, observation, diaries and documents: a detailed depiction of events and action.
- Reflexivity. This is the process that Holloway and Wheeler (1996) describe as self-scrutiny. The researcher constantly reflects on how his or her own values, beliefs and personal experience may affect the research.

Quantitative studies exhibit a high level of control over the variables of interest and key characteristics according to Houser (2008). These include:

- Relying on numbers to measure and quantify errors.
- Studying objective characteristics and responses that can be measured.
- Comparing groups of subjects in some way
- Applying interventions to samples to generalise to populations.
- Aiming to determine effects of an intervention through a high level of control.

Combining qualitative approaches with elements of quantitative approaches enabled the researcher to build a wider picture of the phenomena being studied. As the focus of this study was child protection and the perceptions of professionals working in this field were a key component, methodological triangulation was considered to be the most appropriate approach.

Pope et al (2007) asserted that qualitative approaches differ from experimentation and survey approaches, and are an umbrella of activities in which a range of techniques may be used for gaining information. The use of triangulation aims to prevent biases of researchers and overcome deficiencies inherent in single methods (Denzin 1970). It has been suggested that triangulation encourages creativity, flexibility and insight into data collection and analysis, as quantitative methods confirm the findings derived from qualitative data and qualitative methods provide richness to quantitative data (Duffy 1987, Cowman 2008).

The use of methodological triangulation was felt appropriate in allowing the participants an opportunity to share their experiences in practice and an

opportunity for the researcher to explore and validate findings from the responses to the vignettes. The complementary nature of both quantitative and qualitative methods added rigour to the study.

7.3 The research design and approach

The study aimed to explore the perceptions of both health and social service professionals on the extent to which a collaborative approach is adopted when working with families where there are children in need of services or children in need of protection. Given the focus of the study, it was not appropriate to undertake a hypothesis testing study and therefore the study is an exploratory, descriptive account of professionals' views and experience of collaborative working. In the research design, data collection and analysis the researcher has sought to relate the empirical findings to selected key themes identified in the literature review. The research design adopted for the current study was a case study of interagency collaboration in two London boroughs. Yin (1989) defines a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real life context in which multiple sources of evidence are used". A frequent criticism of the case study approach is that its dependence on a small number of cases renders it incapable of providing a generalising conclusion. Hamel et al (1993) and Yin (1993, 1994) argue that the relative size of the sample does not transform a multiple case into a macroscopic study. Yin (1994) goes on to state that generalisation of results from either single or multiple designs is made to theory and not to populations. This means that even a single case could be considered acceptable providing the established objective is met and the study has established parameters. Multiple cases strengthen the results by replicating the pattern matching, thus increasing the confidence in the robustness of the theory. Campbell (1975) asserted that pattern matching is a situation where several pieces of information from the same case may be related to some theoretical proposition. An area where this has commonly been used is medicine.

Yin (1989) describes the strengths of the case study method and states that this method contributes uniquely to knowledge of individual, organisational, social and political phenomena, principally through allowing an investigation to retain the holistic and meaningful characteristics of real life events. The nature of

collaborative working is complex. It is an area that numerous authors have written about from a theoretical perspective and it has been the focus of numerous documents from central government and yet there appears to be no clear understanding as to how to translate that theory into practice. Case study as a method was felt to be appropriate for this complex area due to its holistic approach (Hakim 1987).

Yin (1994) and Stake (1995) identify possible sources of evidence in case studies including documents, archival records, participant observation, direct observation, interviews and physical artefacts. Interviews are one of the most important sources of case study information. Survey is a recognised form of interview in the case study approach according to Yin (1994). The triangulated research design chosen for the current study comprised multiple data sources as described under the headings describing the five stages. In addition a variety of documentary sources were consulted, including guidance from central government, which is discussed in chapter 2.

The case study in the current research progressed through the following stages:

Stage 1

A literature review was undertaken to contextualise the broad and complex field under study and help refine and focus it. Given the length of time the research was in progress, and the changes within safeguarding at both a strategic and operational level, the chapters documenting the literature search were revised to contain more current, relevant findings. The findings from the literature review are documented in chapters 2 – 5.

Stage 2

A comparison of the two boroughs was made with particular reference to:

- indicators of deprivation
- child protection and child in need policies, procedures and guidelines
- child protection registration rates and the levels of children in need of services

The purpose of this stage was to consider the extent to which collaborative working may be influenced as a result of local policy or resources.

The findings of this stage are presented in Chapter 6.

Stage 3

The identification and assessment of relevant population samples was undertaken. This investigation was concerned with the extent to which health and social services professionals perceived a collaborative approach was adopted between the two agencies. The sample of this investigation is therefore a purposive sample. Robson (2002) states that a purposive sample as a form of non probability sampling is appropriate for small scale surveys. A purposive sample is built up which enables the researcher to satisfy her particular need in a project. The sample comprised social workers and health professionals who met the following criteria:

a) They were currently working in the field of general practice, social work, health visiting or school nursing.
b) They were working with/ providing services for families living within one of the two London boroughs.
c) They had had experience within the last 12 months of working with families where there were children either in need of services or in need of protection.

The criteria above were used for identifying the samples for participation in stages 4 and 5.

Stage 4

Stage 4 consisted of a postal survey across the two boroughs using a questionnaire. This stage was administered prior to the publication of the Laming Inquiry. The research commenced in 1999 and stage 4 was undertaken in the period between the end of 2001 and the beginning of 2002. The questionnaire was designed to enable comparison to be made in practice with children in need of services and children in need of protection both between different professionals and between boroughs 1 and 2. The questionnaire was distributed to a total of 311 practitioners working in social work, school nursing, general practice or health visiting in either borough 1 or borough 2.

Stage 5

Stage 5 consisted of a postal survey across the two boroughs using the same questionnaire as stage 4. As this stage took place during the period from the end of 2007 to the beginning of 2008, following the publication of the Laming Inquiry, additional questions were included to explore the impact of the inquiry on practice both when working with children in need and children in need of protection. The questionnaire was distributed to a total of 300 practitioners, working in social work, school nursing, general practice or health visiting in either borough 1 or borough 2.

The initial plan was to undertake interviews during stage 5 of the study with respondents that had participated in stage 4. Due to the delay in undertaking stage 5 and changes that had taken place nationally in the field of safeguarding, the decision was taken to repeat the postal survey for stage 5 as opposed to undertaking interviews.

7.4 Use of theory in the research

Buchanan (1998) presents a review of seven functions of theory: prediction, explanation, making assumptions explicit, understanding, sense making, sensitisation and critique. Schatzman and Strauss (1973) suggest that qualitative studies should be flexible to enable the inclusion of all pertinent theories and assumptions about the subject. They further assert that research needs to add theoretical frameworks to gain conceptual entry into the subject. This is supported by Depoy and Gitlin (1993), who suggest that all research begins from a particular framework based on human experiences and assumptions. Therefore, the framework of key areas to be studied was designed to form the basis of data collection for this study. The key areas to be studied are described later in this chapter in the section that describes the development of the questionnaire. These key areas were only used in the data analysis if they emerged from the data.

7.5 Research methods

The study was a combination of the use of research approaches involving the collection of both qualitative and quantitative data. Whilst it has been acknowledged that direct observation was at the forefront of qualitative research

and one method of data collection in case study methods, other processes have also been used to collect data to provide meaning from participants within a specific context.

Burawoy (1991) distinguishes between the more traditional techniques of participant observation and suggest that the extended case method looks for specific macro determination in the micro world. This approach takes the social situation as the point of empirical examination and works with given general concepts and laws to understand how those micro situations are shaped by wider structures.

For this study, participant observation was not used, due to the ethical dilemmas surrounding the sensitive subject area limiting access, so the decision was made to explore professionals' perceptions through the use of vignettes, which were included in the questionnaires administered by post. In addition, a range of documents including policies and procedures were utilised to elicit the macro perspective.

7.6 The use of postal surveys

Robson (2002) discusses the difficulty in concisely defining a survey as a result of the wide range of studies that have been labelled as surveys, but suggests the typical central features of a survey as include:

- The use of a fixed, quantitative design
- The collection of a small amount of data in standardised form from a relatively large number of individuals
- The selection of representative samples of individuals from known populations

Robson recognises that although these are features commonly present in surveys, they are not always present. Bryman (1989) states that survey research entails the collection of data on a number of units and usually at a single juncture in time, with a view to collecting systematically a body of quantifiable data in respect of a number of variables which are then examined to discern patterns of association.

Robson (2002) identifies a number of advantages and disadvantages of the use of surveys. The advantages include it being a relatively straightforward approach to studying attitudes, values, beliefs and motifs, high amounts of data standardisation and the ease of adaptation to collect generalisable data from almost any population. The disadvantages include the effect of participant characteristics on the data including memory, knowledge, experience, motivation and personality and the fact that respondents may not report their beliefs and attitudes accurately. Robson goes on to suggest there is likely to be a social desirability response bias.

Robson (2002) further cites the advantages and disadvantages of postal surveys. Advantages include the access to large numbers at a relatively low cost in a short period of time and the advantage of the approach allowing anonymity, which encourages frankness when sensitive areas are being studied. Disadvantages include the typical low response rate, the failure to detect misunderstanding of the questions and respondents not treating the exercise seriously. The decision to use a postal questionnaire enabled the researcher to elicit views in a sensitive area of study from a larger sample than some of the other approaches that were considered.

7.7 The development and use of questionnaires

The questionnaire was designed to help achieve the aims of the research and, in formulating the questions; particular care was taken with the wording. Oppenheim (1996) and Sapsford and Jupp (1999) make suggestions for avoiding the most obvious problems including the need to avoid jargon, keeping questions short, avoiding leading questions, removing ambiguity and ensuring the frame of reference for the question is clear. The questionnaire was developed and presented in 4 sections. Section 1 covers a range of descriptive data specific to the respondent and included age, gender, ethnicity, professional background and experience and personal experience of bringing up children. Section 2 presented a series of brief vignettes, based on real life cases which were anonymised. This section explored the opinions of respondents in terms of how serious they assessed the situations in the vignettes to be. This section also assessed whether there was consistency in thresholds across the two boroughs and across professional disciplines. Section 3 presented the long multi staged vignette, where information

was presented in a staged way. This was used to further explore thresholds and to explore collaboration throughout the safeguarding continuum and the understanding of professional roles. Section 4 presented a series of questions to explore the functioning of the local safeguarding network and influences on effective collaboration and stage 5 of the study explored the influence of the Laming Inquiry on safeguarding practice. The questionnaire used a number of open, closed and scaled questions to generate both quantitative and qualitative data to compare participants' perceptions and expectations of the safeguarding system in order to identify likely points of consensus or conflict. Due to the sensitive nature of the research, direct questions for sensitive areas were not used (Brannen 1988, De Vaus 1993) and to explore participants responses in such areas vignettes were developed. The development and use of vignettes will be explored later in the chapter.

In designing the questionnaire the disadvantage of postal surveys in terms of poor response rates was considered and steps taken to increase the chances of a better response rates. Factors that have been identified by Robson (2002) as improving response rates in postal surveys include:

- Ensuring the appearance promotes a feeling of the questionnaire being easy to complete and allowing adequate space for responses
- Clear instructions
- Starting with questions requiring easy answers progressing to those needing more thought
- Address the envelope to the participant by name
- Use of first class postage, stamped not franked
- Inclusion of a stamped addressed envelope for return of the completed questionnaire
- A covering letter detailing the aim of the research, its importance, assuring confidentiality and encouraging response
- Use of a range of approaches to follow up non response

The limitations in exploring qualitative areas solely through the use of questionnaires is acknowledged in that the subtleties of respondents' experience, understanding and motivation are unlikely to be fully captured, even with the use of open ended questions. The other issue is that raised by Finch (1987) who points out that it cannot be assumed that expressed intentions predict behaviour. This issue is not only a consideration with the use of questionnaires but is also an issue when using interviews.

7.8 The development and use of vignettes

A number of vignettes were prepared from health professionals' and social workers' case notes, reflecting 'real life' situations and were fictionalised to an extent to preserve anonymity and to permit the systematic coverage of a wide range of situations e.g. whether the race of the child affected the approach to case management. The researcher selected cases on which vignettes were based with care and ensured that in preparing the vignettes, no individual could be recognised. This technique has been widely used in social psychology to examine the basis of individuals' moral reasoning.

Vignettes have also been used to study professional decision making by health visitors and social workers in terms of defining child abuse (Giovannani and Becerra 1979, Fox and Dingwall 1985, Birchall and Hallett 1995). At the time the research commenced there were few detailed accounts of the use of vignettes, particularly within qualitative research and as a complementary method with other data collection techniques. Finch (1987) describes the use of vignettes within a quantitative paradigm, although others offer definitions of their use within qualitative research (Hughes 1995, Hazel 1995, Hill 1997, Hughes 1998). Throughout the time the research was in progress further studies were published, using vignettes (Taylor et al 2009). Although vignettes can be employed in different ways and for different purposes, generally they fulfil three main purposes:

1. Interpretation of actions and occurrences that allows the situational context to be explored and influential variables to be elucidated
2. Clarification of individual judgements, often in relation to moral dilemmas
3. Discussion of sensitive experiences

Neal (1999) describes the use of vignettes in exploring potentially sensitive topics and suggests commenting on a story is less personal than talking about direct experience and is often viewed by participants as less threatening. The use of vignettes is said to improve the engagement of respondents and to elicit more meaningful and considered answers than the usual questionnaire and thus they have a particular value in exploring attitudes (Finch 1987).

Vignettes have also been used to examine different groups' interpretations of a "uniform" situation. Barter and Reynold (1999) used vignettes to explore how young people, residential care workers and managers evaluated different forms of violence between children. There are also examples of their use to elicit cultural norms derived from respondents' attitudes and beliefs about a specific situation. Finch (1987) explores the merits of using more than one vignette, varying the content with respect to factors such as age, gender and ethnicity. A number of researchers have used vignettes as a complementary technique alongside other data collection methods, namely observation and interviews (Hazel 1995, Hughes 1998). This approach reflects concerns raised by researchers who refer to the danger of using this approach in isolation, and suggest the indeterminate relationship between beliefs and actions is the main concern (Faia 1979). Hughes (1998) concludes that not enough is known about the relationship between vignettes and real life responses to be able to draw parallels between the two. The inclusion of vignettes in multi method approaches may clarify some of these methodological issues.

Prior to their use in the research, the vignettes were piloted as part of the process to pre-test the whole questionnaire. This aimed to test the length of time it took participants to complete them, to check questions and instructions were clear and to enable items to be removed that did not yield usable data. Ten professionals not involved in the research were asked to pilot the vignettes. Minor alterations were made in line with the feedback from the pilot.

The objective of stages 4 and 5 was to:

- Assess how convergent or otherwise respondents' perceptions of cases were in terms of assessing thresholds of concern (Gibbons et al 1995)
- Assess the individual's perception of their role throughout the child protection process
- Assess the individual's perception of the role of other professions throughout the child protection process

The additional objective of stage 5 of the study was to:

- Compare practice in the field of safeguarding children at the time the original questionnaire was distributed, prior to the publication of the Victoria Climbié Inquiry Report, with practice following the publication of the report.

If professionals are to work collaboratively it is important they share a common understanding about what constitutes a child in need or child abuse.

7.9 The piloting of the questionnaire

The draft questionnaire was pre tested in two stages. Initially it was pre tested with colleagues who were asked to provide constructive comments on the wording of the questions. Feedback was incorporated into the amended questionnaire and the amended version used as part of a pilot. The pilot was used to pretest the questionnaire (Baker 1994). At this stage, ten professionals whose roles were similar to those in the sample but who were not included in the research agreed to pilot the questionnaire. The pilot aimed to improve the validity of the research by following the approach as suggested by Peat et al (2002) which included:

- administering the questionnaire to pilot subjects in exactly the same way as it will be administered in the main study
- ask the subjects for feedback to identify ambiguities and difficult questions
- record the time taken to complete the questionnaire and decide whether it is reasonable
- discard all unnecessary, difficult or ambiguous questions
- assess whether each question gives an adequate range of responses
- establish that replies can be interpreted in terms of the information that is required
- check that all questions are answered
- re-word or re-scale any questions that are not answered as expected
- shorten, revise and, if possible, pilot again.

Feedback from the pilot was considered and the questionnaire amended to reflect the feedback. The main amendments involved minor rewording of questions to ensure clarity. It is recognised that pilot studies do have limitations and in administering the final questionnaire, it became apparent that it would have been more appropriate to use smaller ranges where participants were asked to respond in terms of percentages. Following the amendment of the questionnaire prior to stage 5, the newly inserted questions were again piloted on a group of 5 professionals, not participating in the research project. At this stage no amendments were suggested. No further amendments were made to questions used in stage 4, as the researcher wanted to keep questions, other than those added in response to Laming, the same for the two stages for the purpose of comparison.

7.10 Sampling frame

A sampling frame was developed for the selection of participants for the interviews to minimise bias. The sampling frame for selection of participants included:

- Currently practising as a social worker, GP, school nurse or health visitor
- Experience of working with children in need of services
- Experience of working with children in need of protection
- Relatively equal number of participants selected in borough 1 and borough 2.

7.11 Ethical considerations and negotiating access

Ethical approval was obtained from borough 1 research ethics Committee on 12.11.1999 and borough 2 research ethics committee on 16.9.1999. On 9.2.2000 the research ethics committee in the university gave ethical approval. Following the publication of the Laming Inquiry (2003) the decision was made not to undertake interviews as originally planned but to develop the original questionnaire to include additional questions to explore the impact of the inquiry on practice. This resulted in the need to gain approval for the change in approach from the local research ethics committee and approval for the amended approach was granted on 26.10.2007. Following approval stage 5 of the research was undertaken between the end of 2007 and beginning of 2008. During the period the research was in progress, there was development in policy in the UK that culminated in the introduction of the research governance framework in health and social care in 2001 (DOH 2001a), which specified roles and responsibilities of researchers, participants, managers, hosts and funders. This led to new procedures and processes and meant that at the stage the changes in the current research were proposed, following approval from the local research ethics committee, approval needed to be sought from the research and development committees for both sites. The permission from one site was gained relatively quickly; however, due to the different level of understanding and interpretation of what the process was and who led on the process across the second site, this resulted in numerous difficulties, and considerable delay before permission to undertake stage 5 was gained. Cook et al (2007) detail similar problems being experienced by researchers

in their paper describing the experiences of a research team seeking approval in 357 NHS organisations.

Prior to both stages 4 and 5, letters were sent to the appropriate managers and chief executives and to individual GPs with a detailed account of the research project. Responses were generally supportive and permission to approach professionals granted. For stage 5, health managers within one of the boroughs gave permission but were concerned about time demands on staff and clearly indicated non response was not to be followed up. This resulted in a lower response rate than may have been achieved and is further detailed in chapter 8.

A letter was sent to all participants, giving comprehensive information on the study, including information in the areas of confidentiality and data storage and disposal. It is acknowledged that some participants may feel threatened, believing their practice was under scrutiny and therefore clear explanation as to the extent to which confidentiality would be maintained was essential.

Participants were requested to sign a written consent form and were advised of their right to withdraw from the study at any point. In the letter information was given in relation to services available to the participants in recognition of the stress that could occur in participating in a study addressing a sensitive area of practice. The subject area safeguarding children is one that can result in emotional stress and the researcher was keen that the enquiries within the research should be non-maleficent in character (Beauchamp and Childress 1994). There were no instances where participants became distressed and therefore support services offered were not required.

7.12 Methodological rigour

The success of research activity depends on the methodology used to convince others of the credibility of the research findings (Avis 2006). Validity is a concept used by researchers to assure the research community about the authenticity of evidence from research findings. However Avis (2006) states that there is evidence to show that the process of assessing validity of research findings is different between sections of the research community and differs according to

the criteria used to establish the credibility of research findings. The positivist paradigm that underlies quantitative research is often based on the belief that there is one reality that can be observed and assessed through the process of research. Qualitative research has other important dimensions used for validity, including adequacy, trustworthiness, accuracy and credibility.

Internal validity refers to the extent to which an instrument will measure what it is intended to measure and external validity refers to the extent to which the instrument will provide data which will be compatible with other relevant evidence (Burns et al 1993). Internal validity, therefore relates to the confidence that can be placed on a specific instrument to produce a desired outcome whilst external validity on the other hand is concerned with the extent to which research findings can be generalised to other samples and settings. However it is essential to recognise the effects of variables external to the instrument, which may affect the evidence.

Reliability refers to the extent to which a measure of a concept delivers the same results no matter how many times it is applied to random members of the same target group. A number of authors have suggested that the criteria for reliability and validity can be used to assess the credibility of both qualitative and quantitative research findings (Duffy 1985, Kirk and Miller 1986, Johnson 1997, Polgar and Thomas 1997). Lecompte and Goetz (1982) argued that although qualitative research is exposed to different threats such as accurate representation arising from its interactive methods and interpretive analytical techniques, the same criteria of reliability, internal and external validity can be used as that used to assess the credibility of quantitative research findings. Avis (1995) also suggested that the epistemological issue central to validity is how an empirical account can be shown to be an adequate representation of the phenomena. At the commencement of the study, the researcher was working within one of the organisations included in the study. The "insider" effect is recognised by Hammersley and Atkinson (1983) who assert that there has to be some degree of both social and intellectual distance as it was the distance that created the opportunity for analytical work. In recognising the possibility of introducing bias as a direct result of the researcher working within one organisation included within

the study, for part of the time the research was being undertaken and working in the practice area being researched, research chapters were reviewed by another professional to assess objectivity. Minor amendments were made on receipt of comments from this process.

7.13 Response rate

For stage 4 of the research the questionnaire was distributed to a total of 311 practitioners working in social work, school nursing, general practice or health visiting in either borough 1 or borough 2. At the point in time when participants had been requested to return the completed questionnaire, the initial response rate for stage 4 was only 23% (73 questionnaires). For stage 5 of the research, the questionnaire was distributed to a total of 300 practitioners, working in social work, school nursing, general practice or health visiting in either borough 1 or borough 2. At the point in time when participants had been requested to return the completed questionnaire, the initial response rate for stage 5 was 32% (96 questionnaires). There was a higher initial response rate for stage 5 compared to that for stage 4. Although it is not possible to identify the reason for this increased response rate, the safeguarding of children was higher on the agenda at both a local and national level at the time the questionnaire was distributed for stage 5 following the response to the Inquiry into the death of Victoria Climbié and other publicised serious case reviews. The fact that safeguarding was high on agendas may have contributed to the improved response rate.

Following the amendment to the questionnaire and the receipt of ethical approval to undertake stage 5, management approval was sought again and unfortunately health managers within borough 1 stipulated that they would consent to their staff taking part but would not agree to staff being contacted to follow up non response, giving work load pressures as the rationale for that decision. As a result, for stage 5 of the study, follow up approaches were only used for borough 2 and social workers in borough 1. This resulted in a lower final response rate than may have been achieved.

Initially, the traditional approach of sending out a written reminder with another blank questionnaire and protocol was used to follow up non returns. Following

this, the professional groups with the poorest response rates were identified. In addition to the written reminders, telephone contact was made with non-respondents in this group. The purpose of the telephone contact was to offer the opportunity to complete the questionnaire by telephone or at a meeting with the researcher, to be arranged at a date, time and venue convenient to the individual. The personal contact approach is one proposed by Polit and Hungler (1995), and although recognised as time consuming, is effective in enhancing response rates.

The use of this approach resulted in a marked increase in response rate from 23% to 55% with 171 questionnaires in total being returned for stage 4 and 32% to 56% with 168 questionnaires in total being returned for stage 5. Although the final response rate was within the expected range for a postal questionnaire as stated by Oppenheim (1996), the final response for stage 5 was disappointing, given the increased initial response in comparison to that in stage 4.

7.14 Data analysis

The data were analysed in two stages. SPSS statistical software was used to perform the analysis of the quantitative data. Frequency counts and simple cross tabulations by professions and borough were done. Where the literature review or the researcher's experience suggested that factors such as age, gender or years of experience might affect them, individual's responses were cross tabulated by these variables. Chapter 8 presents the findings and illustrate the comparison between stages 4 and 5.

There was a large amount of qualitative data generated in both stages 4 and 5. This data needed to be pared down using thematic analysis to identify and present the major themes. Various authors (Dey 1993 and Miles and Huberman 1994) have proposed a variety of analytical frameworks for data analysis. Some authors have focused the importance of analysis as primarily a process of manipulating data involving coding, indexing, sorting and retrieving, whereas others (Coffey and Atkinson 1996) have identified imagination and interpretation as the focus, with the procedural and categorisation seen as the preliminary work. These different assertions and descriptions of data analysis indicate that there is no single right

approach to analysing qualitative data and it may be appropriate to use an eclectic approach.

Miles and Huberman (1994) propose a three staged cyclical process to analysis involving data reduction, organisation of data using visual matrices and the drawing of conclusions and verification of data. The process of data analysis in the current study was based on the framework offered by Miles and Huberman (1994) but incorporated the philosophy of Coffey and Atkinson (1996). The data analysis process involved the data being entered manually on a table and being coded according to borough, professional role and content. The codes used for content were both predefined and developed according to use of similar words emerging during analysis. During the analysis process, codes were reviewed; where they were too broad, sub category codes were developed and where they were too detailed, common responses were grouped under one code. Following the coding process, the findings were examined to identify common themes, patterns and relationships.

In Chapter 8 the findings from the analysis of the questionnaires are presented and discussed.

CHAPTER 8
Results

8.1 Introduction

This chapter will describe and discuss the findings of the two distinct but linked stages of the study, stages 4 and 5. Stage 4 (pre-Laming) of the study was based on the distribution of a questionnaire, which included a number of vignettes reflecting real life scenarios, covering the continuum of children in need of services through to children in need of protection. The scenarios, which reflect situations where children are in need of protection, present situations involving physical abuse, sexual abuse, emotional abuse and neglect. Stage 5 (post-Laming) of the study comprised redistribution of the questionnaire distributed in stage 4. During the time the research was in progress, The Report of the Inquiry into the Death of Victoria Climbié was published, which had a major effect on safeguarding practice. As a result, the opportunity was taken to amend the questionnaire used in stage 4 by developing and adding an additional 3 questions.

For both stage 4 and stage 5, the questionnaire was distributed by post. The questionnaire for stage 4 was distributed to a total of 311 practitioners and, for stage 5, to 300 practitioners, working in social work, school nursing, general practice or health visiting in either borough 1 or borough 2. The final number who responded was 171 for stage 4 and 168 for stage 5.

Information will be presented to describe the characteristics of the participants, including age, gender, ethnicity, professional experience and their experience of bringing up children. The findings from the responses within the questionnaires will then be presented to reflect the overall aim of the research project and the objectives the vignettes were designed to achieve, which are discussed in chapter 7. In discussing the findings, reference will be made to the key areas presented in the literature review, including thresholds of concern, perception of roles, multi agency working and the emotional impact of safeguarding work within the context of the management of risk. Comparison will be made of the responses between professional groups, between professionals in each of the two boroughs and

responses in the post-Laming questionnaire compared to the pre-Laming questionnaire. The professional's view of the influence of policy in terms of the Laming Inquiry will be discussed. In presenting the findings that consider multi agency working, the role of communication, cooperation, occupational status and the effectiveness of collaboration across the child in need through to child protection continuum will be discussed.

8.2 Drawing the professional sample

Stage 3 of the research involved the identification and assessment of relevant population samples. The questionnaires for stage 4, the pre-Laming stage and stage 5, the post-Laming stage of the study, were distributed by post. The professional breakdown of distribution in terms of borough and discipline of practitioner is given in Tables 8.1 and 8.2. The percentages in the tables refer to the number of questionnaires distributed to each professional group within that particular borough as a whole.

Table 8.1 -Distribution of questionnaires across disciplines in borough 1

	Pre-Laming		**Post-Laming**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
GP	76	46.2	72	45.9
Social Worker	39	23.6	40	25.5
Health Visitor	39	23.6	37	23.6
School Nurse	11	6.6	8	5.0
Total	**165**	**100**	**157**	**100**

Table 8.2 -Distribution of questionnaires across disciplines in borough 2

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
GP	64	43.8	60	42.0
Social Worker	32	21.9	33	23.0
Health Visitor	41	28.1	41	28.7
School Nurse	9	6.2	9	6.3
Total	**146**	**100**	**143**	**100**

The differences in the percentage of each professional group are a reflection of the numbers working within each professional group in the two boroughs, with more GPs than other professionals and school nurses being the smallest group of professionals.

In both stages 4 and 5 there was noted to be marked differences in response rates both in relation to responses from the different professional disciplines and responses between the two boroughs. The initial response rates for stage 4 ranged between 7.8% for GPs in both borough 1 and 2, to 74.3% for health visitors in borough 1. In stage 5, the initial response rates ranged between 11.1% for school nurses in borough 2 to 87.5% for school nurses in borough 1. Although the response rate for GPs was better in stage 5 than in stage 4, it remained low with 11.6% of GPs in borough 2 responding and 19.4% in borough 1.

Poor response rates are a recognised disadvantage of postal questionnaires. Response rates for postal questionnaires typically range between forty and sixty per cent (Oppenheim 1996). The initial response rate in the current research, although at this stage being lower than the expected rate based on the work of Oppenheim (1996), was higher in borough 1 than in borough 2, for both stages 4 and 5 and was higher in both boroughs for stage 5, compared to stage 4.

As a result of the initial poor response rates, consideration had to be given to the approach used to follow up non returns to maximise the chances of significantly improving the final response rate. It was decided that innovative follow up approaches would need to be identified if a reasonable response rate was to be achieved and the follow up approaches used are described in chapter 7. For stage 4, non responses were followed up across boroughs 1 and 2. However, as has been discussed in chapter 7, permission for follow up of non response was not granted for health professionals in borough 1 during stage 5, and, as a result, follow up was only undertaken for social workers across both boroughs and health professionals in borough 2.

The breakdown of total final responses by borough and discipline is given in Tables 8.3 and 8.4. The percentages in the tables refer to the number of questionnaires distributed to each professional group within that particular borough as a whole.

Table 8.3 - Final response rate in borough 1

	Pre-Laming		**Post-Laming**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
GP	36	47.3	14	19.4
Social Worker	21	53.8	23	57.5
Health Visitor	31	79.4	26	70.2
School Nurse	6	54.5	7	87.5
Total	**94**	**56.9**	**70**	**44.5**

Table 8.4- Final response rate in borough 2

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
GP	29	45.3	32	53.3
Social Worker	14	43.7	18	54.5
Health Visitor	29	70.7	39	95.1
School Nurse	5	55.5	9	100
Total	**77**	**52.8**	**98**	**68.6**

The total final sample of 171, from both boroughs, for stage 4 consisted of 65 GPs, 35 social workers, 60 health visitors and 11 school nurses.

The total final sample of 168, from both boroughs for stage 5 consisted of 46 GPs, 41 social workers, 65 health visitors and 16 school nurses.

In terms of the response rates in both stages 4 and 5, GPs are under represented, considering that they accounted for in excess of 40% of questionnaires distributed for both stages. The GP response rate was 20.9% of the total questionnaires distributed for stage 4 and 15.6% for stage 5. In terms of response rates of the total number distributed to each discipline, in total 46% of GPs responded in stage 4 and 35% in stage 5, 49% of social workers responded in stage 4 and 56% in stage 5, 75% of health visitors in stage 4 and 83% in stage 5 and 55% of school nurses in stage 4 and 94% in stage 5. The increase in school nurse response may be indicative of the changes to the profession, characterised by a closer alignment of school nursing to health visiting in terms of both the training and changes in salary banding. Another factor that could have influenced the response rate by school nurses is the fact that Victoria Climbié was a school-age child which helped to shift the emphasis of child protection work from the focus on the youngest age group to the recognition that older children can also be affected.

Although the response rate for GPs is lower than for the other professional groups within the study, it is higher than the response rate of 18% achieved by Tompsett et al (2009) in their research, which explored the range of conflicts, interests and tensions that might constrain the participation and engagement of GPs in safeguarding children and child protection processes.

8.3 The characteristics of the participants

In this section of the chapter, a number of characteristics of the participants will be described. The age range, gender and ethnicity of professionals were similar in both borough 1 and 2. The age range of participants in relation to their professional discipline is given in Figures 8.1 and 8.2

Figure 8.1 – Participants age range by professional discipline pre-Laming

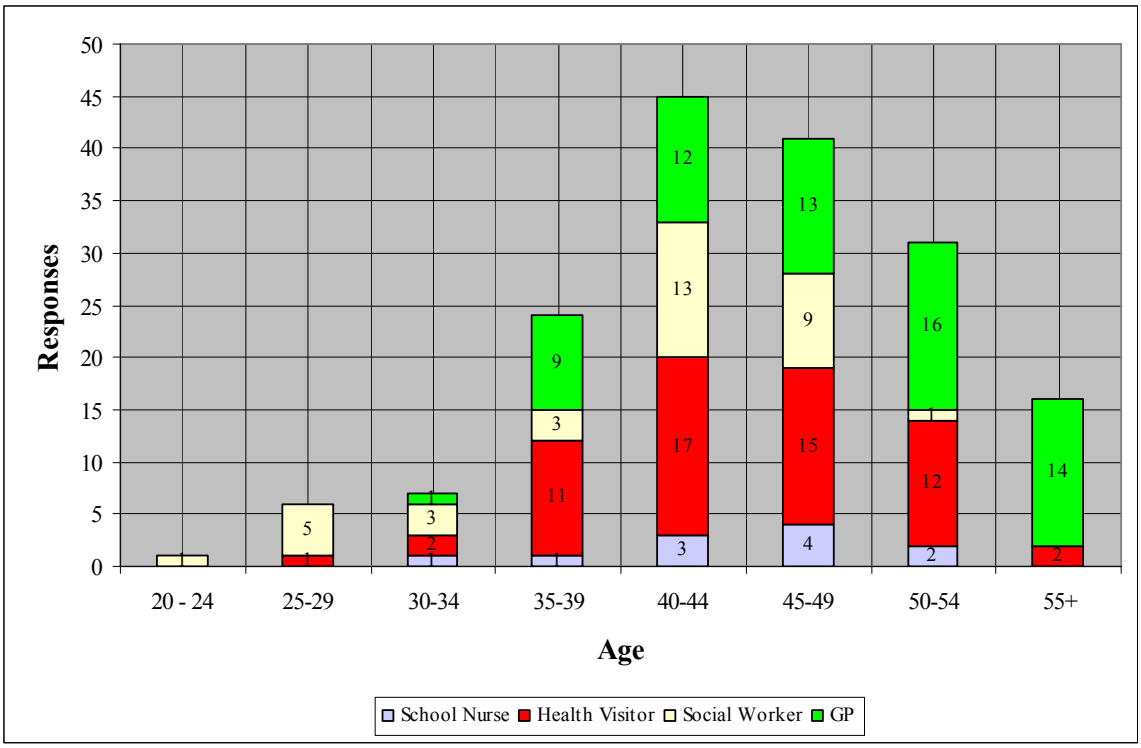
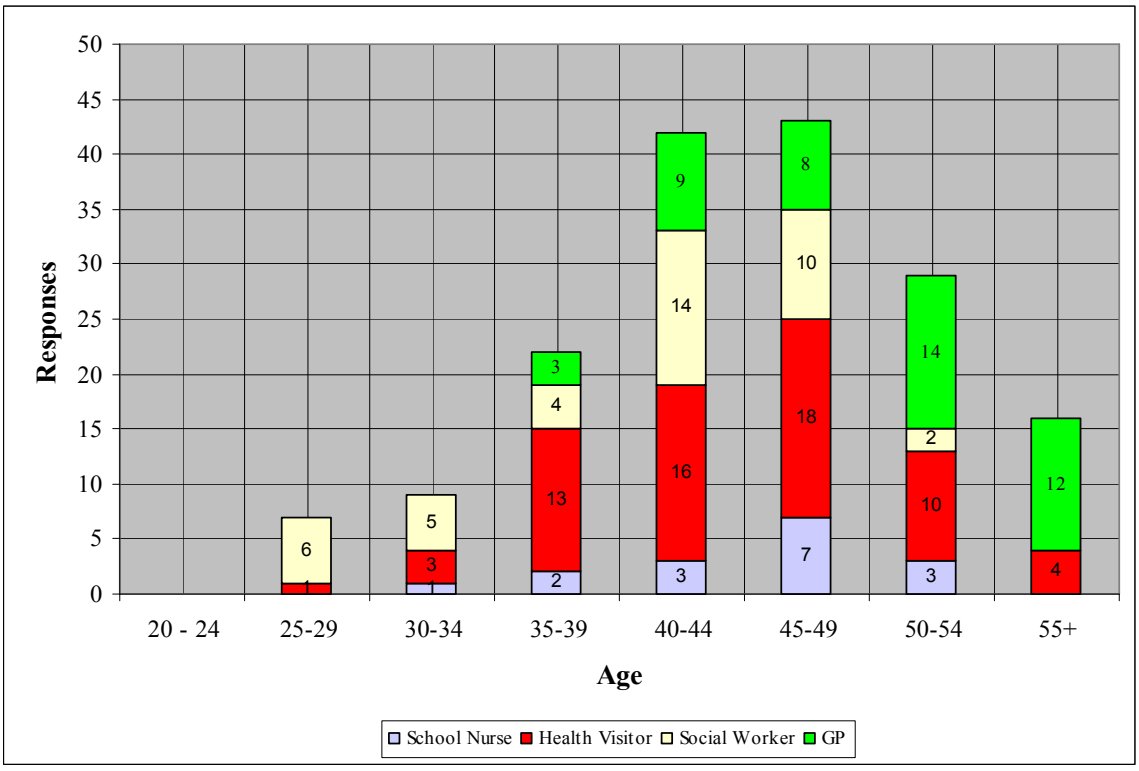


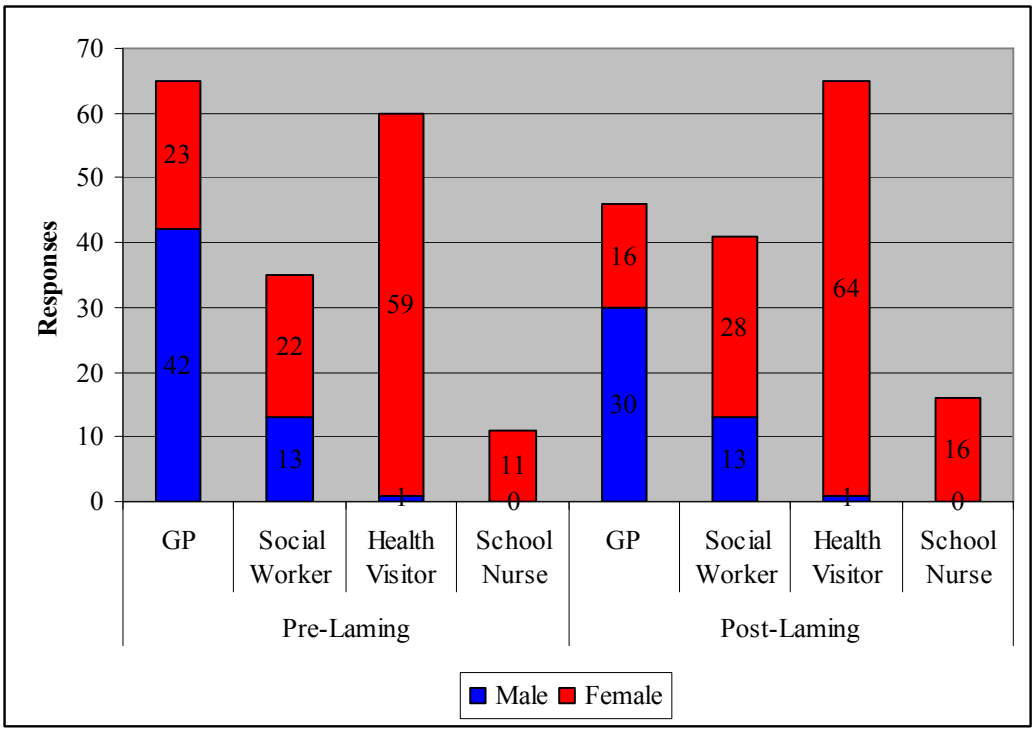
Figure 8.2 – Participants age range by professional discipline post-Laming



In line with the national picture, the findings for both stages 4 and 5 reveal the demographic trends of a high number of health professionals working in both borough1 and 2, falling into the older age groups. This was less evident for social workers. In terms of health professionals, there were, in particular, a higher number of GPs aged 50 or above.

The gender distribution of the sample is given in Figure 8.3.

Figure 8.3 – Gender of participants pre- and post-Laming

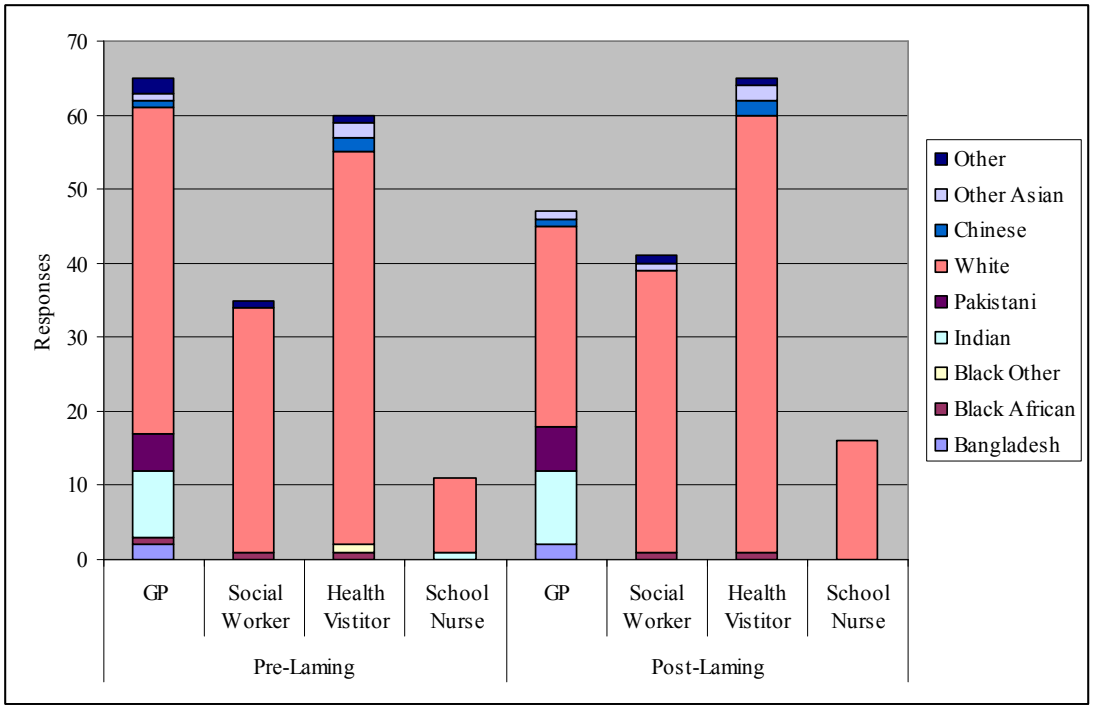


Overall, there is a much higher percentage of females in the sample both at stages 4 and 5. This is more so for health visiting and school nursing. This is reversed for GPs, where there are more males than females. A number of researchers have examined cultural organisational boundaries by looking at gender-shaped beliefs, norms and values (Eagley 1987, Martin 1999, Evetts 2000, Perrott 2002). They conclude that gender is being reproduced at both a cultural and a structural level and that, on the one hand, culturally embedded gender stereotypes reinforce the gender role theory according to which some jobs require feminine traits such as nurturing in social care, whereas some others call for masculine attributes such as law enforcement in the police. They further state that, on the other hand, organisational procedures such as job descriptions can subtly imply that certain jobs are more suitable to people of one gender. In reviewing the available literature, although there is research available that considers the impact of the carer's gender on child protection work (Farmer and Owen 1998), no research was found that specifically considered gender in professionals and their responses in child protection work.

Ethnicity

The ethnic origin of participants within the sample is given in Figure 8.4.

Figure 8.4 – Ethnicity of participants pre- and post-Laming



In the initial plan for the project, the intention was that the research would include an analysis of the effects of the ethnicity of professionals in making judgments regarding child protection issues. In analysing the results, it has been found that the overriding ethnic group is white, which makes any analysis statistically insignificant. In considering statistics of children subject to a child protection plan (DFES 2006), there is an over-representation of children from ethnic minority groups, whilst statistics published by the Department of Health reveal an under-representation of professionals working within safeguarding from ethnic minority groups (Department of Health 1997a).

Thanki (2007) states that children from black and ethnic minority groups in need of protection receive a poor response from both health and social care professionals, with professionals demonstrating reluctance to intervene or adopting Eurocentric approaches that fail to meet the needs of a culturally diverse society.

The term Eorocentric approaches is not specifically defined by Thanki. Ibanez et al (2006) undertook research in the US to examine cultural factors that may influence physical abuse reporting by professionals. The findings revealed that the ethnicity of the respondent was a significant predictor of reporting tendencies for African American respondents only. For African-American respondents, higher levels of ethnic identity and acceptance of corporal punishment were significant mediators of reporting tendencies.

Experience of research participants

The professional and personal experience of participants within the sample was considered, to establish whether there was any association between experience and responses given. Francis et al (2006) found in their study that the older more experienced professionals operated at a higher threshold and were more willing to manage risk, whereas the less experienced practitioner showed a tendency to be more risk averse. The profession, experience of working in the area of children in need and children in need of protection, the number of years in that profession and personal experience of bringing up children are given in Tables 8.5, 8.6, 8.7 and Figures 8.5 and 8.6. The results for both borough 1 and 2 showed no significant differences.

Table 8.5 - The period of time spent by participants in their current role

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
0-10 years	52	30.4	28	16.7
11-20 years	71	41.5	79	47.0
21-30 years	42	24.6	52	30.9
30+years	6	3.5	9	5.4
Total	171	100	168	100

The information in Table 8.5 indicates the length of time participants had spent in the role of GP, health visitor, school nurse or social worker. In the stage 4 samples, approximately 30% of the participants had less than 10 years experience

whilst in the stage 5 sample this was approximately 16%. One explanation of this difference could be the reduction of the numbers being sponsored for training in some of the professions included in the research. The majority of participants in both stages 4 and 5 had 11-20 years experience in their current position. The importance of professionals with adequate experience and training to support that experience is recognised by Brandon et al (2009), given the complexity in effectively undertaking work to safeguard children.

Table 8.6 - The period of time spent by participants in their current post

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
0-10 years	113	66	128	76.2
11-20 years	49	28.7	33	19.6
21-30 years	9	5.3	7	4.2
30+years	0	0	0	0
Total	171	100	168	100

Table 8.6 indicates the length time participants had spent in their current post. The information suggests that in stage 5 there was an increase in the percentage of participants who had been in their current post for less than 10 years. Combined with the data from the previous table this appears to demonstrate that, although there was a more experienced workforce in stage 5, this workforce was more mobile.

Table 8.7 – Participants' personal experience of bringing up children

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Has experience	154	90.1	147	87.5
Has no experience	17	9.9	21	12.5
Total	171	100	168	100

Table 8.7 shows the number of participants who have personal experience of bringing up children. It is recognised that individuals utilise not only their professional experience in practice but their personal experience and value and belief systems. Jones and Brown (1991) describe the process of personal representation of a problem, where individuals, by using legitimate critical thinking processes, can arrive at different interpretations of the same situation. This is as a result of the situation being viewed in the context of the individual's own experience and philosophical approach rather than being purely analytically driven. The results of the current study found that, for both stages 4 and 5, the majority of respondents had personal experience of bringing up children; therefore the results would be statistically insignificant for use in cross tabulation in terms of their decision making in relation to children in need of services or protection.

The percentage of time that participants had spent working with children in need and children in need of protection in the previous month and whether this reflected their usual working pattern was considered. The responses are documented in figures 8.5 and 8.6.

Figure 8.5 – Percentage of time spent working with children in need in the previous month and whether the time spent was typical

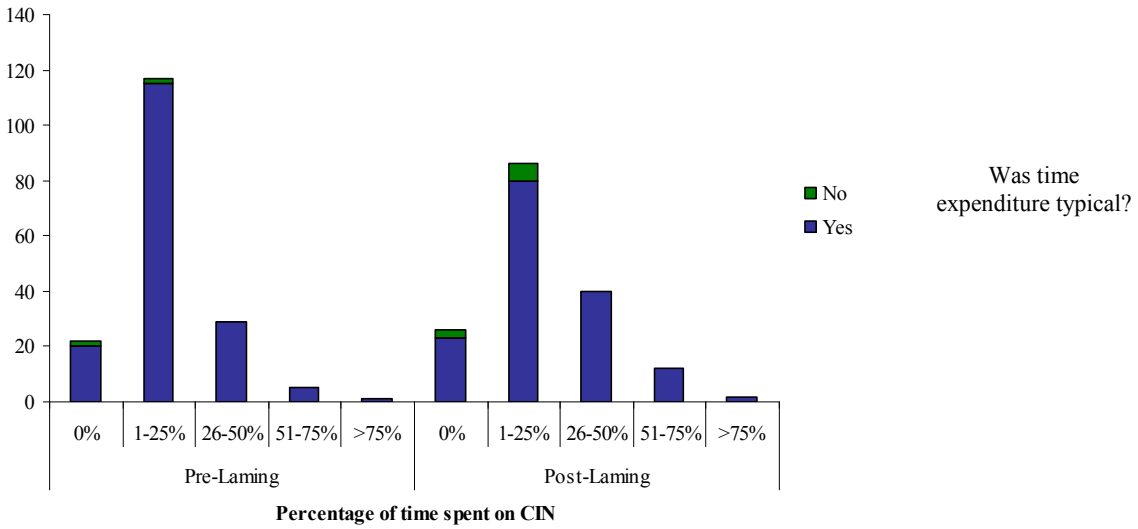
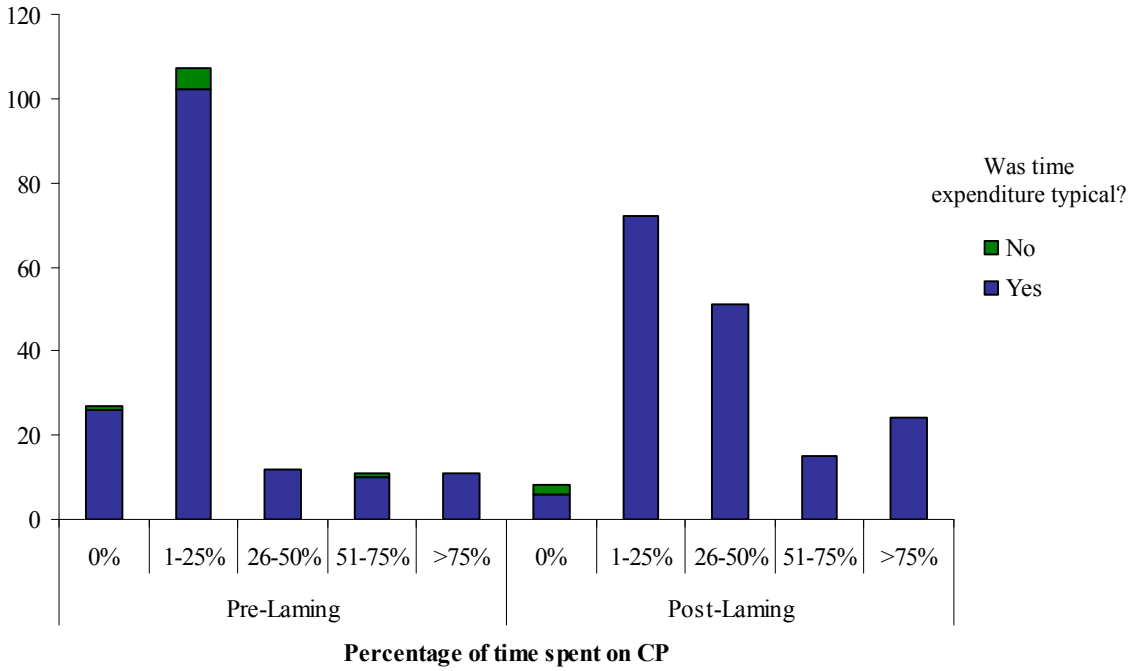


Figure 8.6 - Percentage of time spent working in child protection in previous month and whether the time spent was typical



In comparing the results for stages 4 and 5, there is an increase in the number of respondents who indicate they had spent no time working with children in need in the previous month, a decrease in the number of respondents who indicate they had spent no time working with children in need of protection in the previous month and an increase in the number of respondents who had spent above 75% of their time with children in need of protection in the last month. In terms of the respondents who indicated they were spending no time in work with children in need, over 75% of respondents in this group were GPs and this may be due, in part, to their lack of familiarity with the child in need system and whether they had been invited to participate in the process.

In reflecting upon the questionnaire design, the researcher recognises that it may have been more meaningful to have set out the options of intervals of 10% as opposed to the 25% included in the questionnaire. People who have less exposure to working in the field of child protection may be less consistent in their decision making than practitioners with more experience of the work. Therefore, setting

out the options differently would have enabled a more meaningful comparison to have been made between experience of the practitioner and the judgments made in response to the vignettes.

8.4 Thresholds of concern

Participants were presented with vignettes based on real life cases. Each of the vignettes that follow describe a case that may have been classified as a child in need of services or a child in need of protection as a result of physical injury, sexual abuse, emotional abuse or neglect. Some cases were selected to elicit greater unanimity and others to be more ambiguous.

Scenario 1 – A 3 year old child from a two-parent family, who have recently arrived in England from Kosovo seeking political asylum, found wandering across a main road.

Scenario 2 – A 4 year old child from a two parent white British family whose father frequently shows the child's friends pornographic videos.

Scenario 3 – An 8 month old white British child living with two parents. Both parents have learning disabilities. The child's weight gain has continued to be slow and at 8 months is below the 4th centile. At birth the weight was above the 25th centile

Scenario 4 – A 7 year old white British child living with her mother. On one occasion the police visit the home having received a call from the child describing her mother as drunk. On arrival at the house the child is at home with her mother and the mother is found in a "drunken state". No food is found in the home.

Scenario 5 – A 9 year old white British child living with two parents. The child frequently witnesses domestic abuse and on several occasions has witnessed his father being arrested following such incidents. The child has recently been excluded due to his aggressive behaviour to other school children.

Scenario 6 – A 6 year old Nigerian child lives with a one-parent family. At a recent access visit to the child's father, a hand mark is noted on the child's shoulder. The child reports this was as a result of being hit by the mother for being late home from school.

Scenario 7 – A 16 year old Asian girl living with both parents who reports her father has had sexual intercourse with her regularly for several years.

Scenario 8 – A 6 year old Nigerian child living with his mother who has had a long history of suffering with mental health problems. There are no toys apparent in the home and the mother provides no stimulation for the child. School attendance is poor.

Scenario 9 – A 4 year old Asian child whose parents constantly criticise, stating they wish the child had never been born and constantly compare the child to the younger siblings.

Scenario 10 – A 10 week old white British baby living with both parents is admitted to hospital and is diagnosed as having had a cerebral haemorrhage that is consistent with severe and sustained shaking.

Participants were asked to rate the incident on a scale of increasing seriousness in relation to the welfare of the child from 1 to 5, a score of 1 related to the incident being very serious and a score of 5 being not very serious. The responses are given in figure 8.7 and 8.8

Figure 8.7 – Respondents' perception of the degree of seriousness of scenarios presented pre-Laming

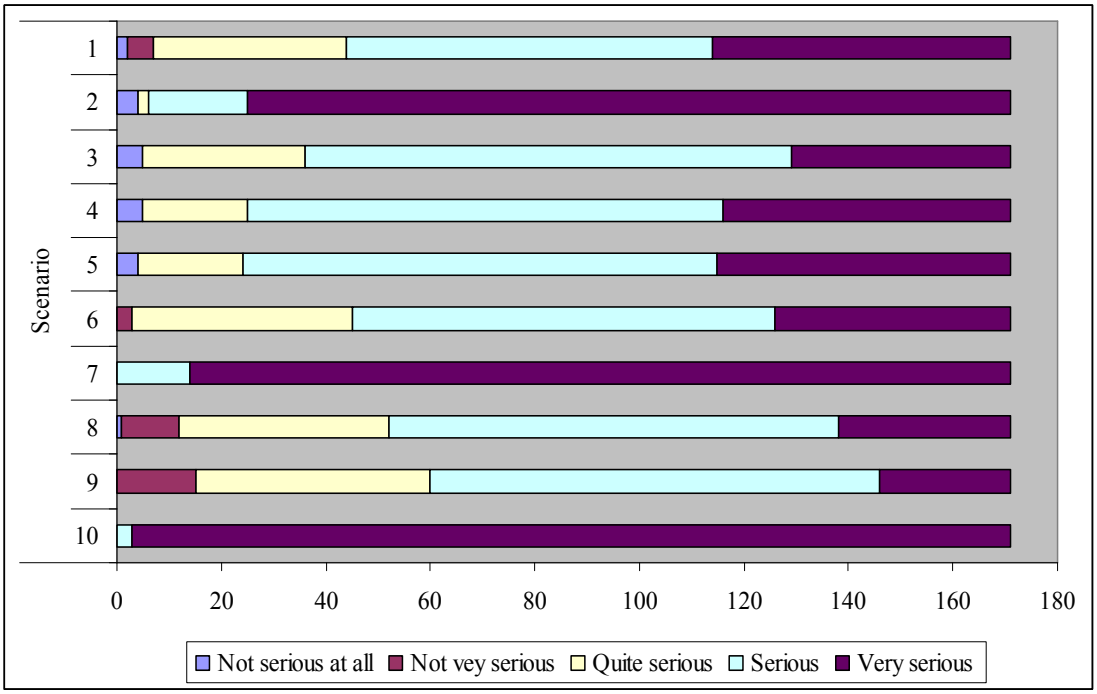
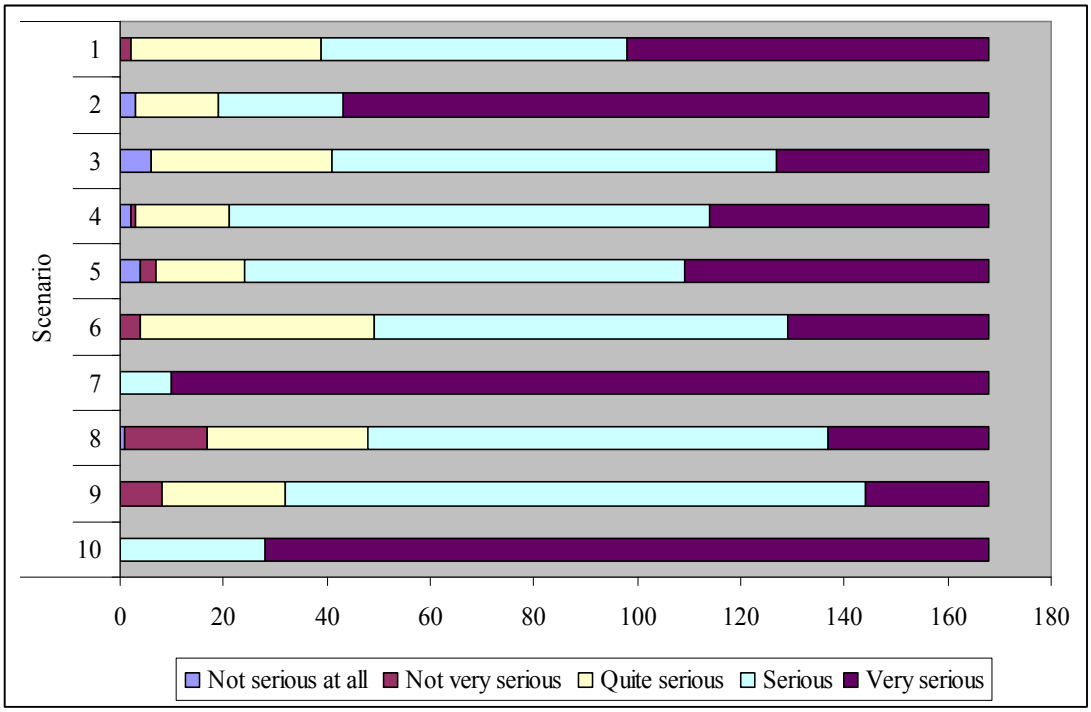


Figure 8.8 – Respondents' perception of the degree of seriousness of scenarios presented post-Laming



The responses to the vignettes demonstrated a lack of consensus in several of the cases in terms of thresholds of concern. Notably there was a greater degree of consensus in the two cases of sexual abuse, with 100% of respondents rating scenario 7 as serious or very serious and only a very small percentage not rating scenario 2 as serious or very serious. This would indicate that the majority of respondents recognise the exposure of a child to pornography by definition is sexual abuse. There was also a high degree of consensus in the case of physical abuse in a baby in both stages 4 and 5. There are differing assessments in terms of thresholds of concern in the cases presented that describe children in need of services and those that presented issues of neglect and emotional abuse. In some ways, this is not surprising, as sexual and physical abuse can be more definitive whilst emotional abuse and neglect need a more longitudinal assessment and committed response from all agencies. In practice, national league tables publicise whether the required timescales in which initial and core assessments need to be completed have been achieved, which promotes a culture of assessment being reduced to a snapshot in time. In cases of neglect, there are unique difficulties in agreeing the benchmark and in determining cause and effect. The lack of consensus has been found in a number of research studies (Dingwall et al 1983, Hallett and Stevenson 1980, Dale et al 1986, Corby 1987). Hallett and Stevenson (1980), Dale et al (1986) and Dingwall et al (1983) state that contributory factors to the different assessments and decision making include inter-professional conflict and defensiveness whilst Corby (1987) found little inter-professional disagreement over cases of serious abuse but very evident disagreement in more marginal cases.

In the current study, there was also less consistency in the assessment of the child in need cases which may, in part, be due to the less well established child in need system or lack of exposure to the work. These findings concur with those of Aldgate and Tunstill (1995) and Colton et al (1995). The findings raise the issue as to whether the complexity of children's lives can be fully understood. Another consideration is the influence of the organisational culture. Research studies that considered the implementation of The Children Act 1989 (Department of Health 1995a, Department of Health 2001) reveal that authorities were finding it challenging to shift their focus from the limited perspective of statutory duties.

Brandon et al (1999) found that over half of the authorities in their study still used the child protection threshold for access to services four years after the implementation of the 1989 Act. The consequence of this failure to successfully refocus services is that a number of children and families struggle to access services before crisis occurs (Macdonald and Williamson 2002, Axford et al 2003, Axford and Little 2006).

The experience of respondents was considered in relation to the responses given and notably there were significant differences in the responses from those working in borough 1 compared to those working in borough 2, and between different professionals. The different responses are recorded in tables 8.8 and 8.9.

Table 8.8 – Percentage of respondents who perceived the incident to be serious or very serious

	Pre-Laming				Post-Laming			
	GP	**Social Worker**	**Health Visitor**	**School Nurse**	**GP**	**Social Worker**	**Health Visitor**	**School Nurse**
Scenario	%	%	%	%	%	%	%	%
1	74	77	66	80	82	82	69	73
2	86	100	100	100	72	82	100	100
3	70	74	80	88	63	69	80	90
4	60	88	92	100	69	88	93	100
5	81	89	92	82	75	84	96	87
6	75	66	78	73	60	70	81	71
7	100	100	100	100	100	100	100	100
8	55	73	80	70	58	72	84	72
9	52	66	80	46	76	80	88	80
10	100	100	100	100	100	100	100	100

In comparing responses according to disciplines, there is a lack of agreement in relation to the degree to which individual scenarios were assessed as being serious or very serious. Scenarios 7 and 10 which relate to physical and sexual abuse were

consistently assessed as very serious across all disciplines. In the case of the other scenarios, in general, GPs are less likely to rate a problem as serious. This was more marked in the post-Laming survey, with GPs rating 7 of the 10 scenarios less serious than the other 3 professional groups. This could be evidence that the other disciplines have developed their knowledge and skills further since Laming (2003) than GPs. Within the most recent Laming report, following the death of Baby P in Haringey (Laming 2009), GPs have been identified as not demonstrating full engagement in the safeguarding processes. Laming recommended the route to the achievement of improved participation by GPs in safeguarding children to be through the development of the legislative process.

In comparing the responses pre and post Laming there are a number of occasions when a professional group's response exhibits an increase or decrease in excess of 10%. In response to scenario 2, 14% less GPs assessed the scenario as serious in the post-Laming stage in comparison to the pre-Laming stage. For the same scenario, there was an 18% decrease in social workers assessing the situation as serious. In response to scenario 6, 15% less GPs assessed the scenario as serious in the post-Laming stage in comparison to the pre-Laming stage. In response to scenario 9, 24% more GPs, 14% more social workers and 34% more school nurses assessed the scenario as serious, in the post-Laming stage in comparison to the pre-Laming stage. Changes in response rates do however need to be treated with caution when response numbers are small.

There is no clear pattern of differentiation between social worker and health professional assessment in either the pre or post-Laming surveys. School nurses in both the pre- and post-Laming surveys were more likely to assess scenarios involving pre-school children, as was the case for scenario 1 pre-Laming and 2 and 3 pre and post-Laming as more serious in comparison to the other professionals. This may be due to a lack of confidence in assessing an age group that they do not provide services for, given that school nurses' expertise is in working with children of school age, whilst the other professionals are more generic.

Table 8.9 - Percentage of respondents in each borough who perceived the incident to be serious or very serious

	Pre-Laming			Post-Laming	
	Borough 1	**Borough 2**		**Borough 1**	**Borough 2**
Scenario					
1	71	78		75	78
2	93	100		84	93
3	70	86		73	78
4	78	92		86	89
5	81	91		78	93
6	63	83		63	78
7	100	100		100	100
8	59	80		69	74
9	62	68		79	83
10	100	100		100	100

In relation to professionals working in different boroughs, respondents in borough 2 consistently assessed scenarios as more serious than professionals in borough 1 in both the pre and post-Laming surveys. Interestingly, at the time, the vignettes were distributed pre-Laming, borough 2 had lower rates of child protection registrations. Borough 2 also had procedures in place for children in need which included multi-agency child in need meetings. This was not in place in borough 1. It is possible that if thresholds in borough 2 were lower and there was a well-established multi-agency approach to meeting the needs of children in need, before they reached the threshold of significant harm, this process may be a significant contributory factor in the lower rates of child protection registration in borough 2. It may be that because borough 2 had the two layered system in place, addressing the continuum of children in need through to children in need of protection, that this led to greater confidence in the decision making of individual practitioners in assessing the severity of the scenarios. The child in need system in borough 2 would mean there would have been clear multi-agency pathways to direct the problem whereas in borough 1 the only multi-agency response would be child

protection which may have resulted in a lack of direction for how to respond to cases which were not clear cut.

Respondents were asked to consider the factors they considered when making a decision in respect of each of the ten vignettes. This was an open question with no pre selected options given. The factors participants identified they would consider are given in Table 8.10.

Table 8.10 – Factors considered by respondents when assessing the seriousness of scenarios

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Childs well-being	16	9.3	34	20.2
Childs immediate safety	72	42.1	93	55.3
Long term effects	24	14	18	10.7
Ethnicity/Culture	28	16.3	19	11.3
Age of child	30	17.5	42	25
Availability of services	14	8.1	22	13
Parenting capacity	42	24.5	44	26.1
Significant harm evidenced	46	26.9	53	31.5
Strengths/weaknesses	14	8.1	22	13
Single event/sustained	10	5.8	12	7.1

The findings demonstrate that in the post-Laming survey there was more emphasis on the child's wellbeing and immediate safety, the age of the child, availability of services, significant harm evidenced and strengths and weaknesses. This could be due to a greater focus on risk and risk assessment following high profile serious case reviews including Laming (2003) which have criticised the lack of recognition of risk factors and robust risk assessment. The findings also show how

there has been a reduction in the consideration of the long term effects of abuse This is interesting when considering professional responses to scenario 9, which suggests emotional abuse. Table 8.9 demonstrates an increase in professionals in both borough 1 and 2 who assessed scenario 9 as serious in the post-Laming period compared to the pre-Laming period. The overall reduction in professionals' consideration of the long term effects of abuse could suggest that the focus has shifted to only immediate risk factors rather than recognition of the impact that historical factors could have on the assessment. This could raise the question of how robust the supervision process is. There may be a tendency for supervisors to hear the immediate concerns and be able to facilitate the practitioner's decision-making regarding these cases but miss the opportunity to analyse the full historical facts in cases of neglect or emotional abuse.

In Laming (2003) there was an emphasis on the need for issues relating to ethnicity and culture to be taken account of in assessment practice. The research findings do not demonstrate this being identified as an issue, which could be due to the fact that the two boroughs do not have a population or a workforce which is ethnically diverse.

8.5 Perception of roles

In achieving successful collaboration when working with children in need of services or protection, clarity of one's own role and the role of other professionals has been cited by researchers as an essential requirement (Department of Health 1991). Stevenson (1989) analysed the challenges of achieving a collaborative approach and found that different professional groupings find it very difficult to work cooperatively towards a common goal.

Within the current research study the understanding of the individual's own role in safeguarding children and their understanding of the role of other professionals was explored. Participants were also asked to consider a scenario they might come across in the course of their professional work. The scenario was an adaptation of a case that was current prior to the pre-Laming survey in one of the boroughs. Details of the case were amended to ensure full anonymity. The case was selected in addition to the other vignettes as it included issues that posed challenges in

respect of the interface between adult and children's services and involved both pre school and school aged children and was therefore felt to be a more appropriate scenario to explore the roles of different professionals and their understanding of other roles.

The scenario focused upon a three month old baby who was heard by a neighbour to be constantly crying. The house was very dirty and at a recent visit the baby was noted to have severe nappy rash. The mother was 24 years old and the father 28 years old. Both were unemployed and in receipt of benefits. They also had a 6-year-old child.

Participants were asked a range of open and closed questions in a number of stages, each stage supplying participants with more information, reflecting the real life assessment process. They were asked to decide whether they would take any action at each stage. In the pre-Laming survey there was little difference overall in response between professionals and boroughs. In response 100% of GPs, 98% of health visitors, 100% of school nurses and 100% social workers said they would take action. This represented 100% of respondents in borough 2 and 99% of respondents in borough 1.

Although the degree of consensus between professionals was not anticipated given the number of studies that demonstrate differences in decision making, research studies have shown higher degrees of reporting where families were in the lower income bracket (Gil 1970, Becker and Macpherson1988). It may also be that with more recent developments in multi-agency working and education and training consensus around cases may have improved.

The majority of respondents in the current study reported they would take action. The action respondents reported they would take, in response to an open question, is summarised in Table 8.11.

Table 8.11– Actions participants would take in relation to scenario

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Immediate assessment	64	37.4	77	45.8
Liaison with other professionals	92	53.8	118	70.2
Check if known to own agency	73	42.6	88	52.4
Advise client to contact Social Services	11	6.4	12	7.1
Contact to offer support	43	25.1	33	19.6
Inform Social Services	13	7.6	19	11.3
Social Services inquiry	38	22.2	44	26.1
Arrange duty visit	13	7.6	11	6.5

The responses in terms of actions that would be taken varied in both the pre-Laming and post-Laming questionnaire. The response with the highest degree of consensus was the recognition of the need to liaise with other professionals and this was higher in the post-Laming questionnaire compared to the pre-Laming questionnaire, which suggests that the importance of communication across agencies is recognised by a number of respondents. As social service professionals were part of the sample, it would have been more appropriate to ask only health professionals to respond to the questions that relate to liaison with social services and the option of arranging a duty visit as the inclusion of social workers in the sample may have contributed to the low number of responses for these questions.

Respondents were asked whether at this stage they would discuss the case with another professional. In response, there was a variation according to both professional background and the borough worked in. In the pre-Laming questionnaire 100% of school nurses, 94% of social workers, 65% of health visitors and 55% of GPs stated they would discuss the case with another professional. In borough 1 62% of respondents said they would discuss the case with another professional compared to 78% in borough 2.

In the post-Laming questionnaire, 100% of school nurses, 100% of social workers, 98% of health visitors and 62% of GPs stated they would discuss the case with another professional. In borough 1, 89% of respondents said they would discuss the case with another professional, compared to 91% in borough 2.

It is interesting to note that in the post-Laming questionnaire there is a move to a greater awareness of the need to discuss such cases with other professionals and the gap in responses between the two boroughs has closed, although there continues to be a higher number of respondents in borough 2 who indicated that they would discuss the case with another professional compared to borough 1. In both stages GPs had the lowest response in terms of discussing with another professional, which may reflect the lack of an established safeguarding supervision system for this group of professionals in comparison to the other three professional groups. Supervision is a common factor arising in recommendations in serious case reviews and research. This could indicate that practitioners have recognised the benefits supervision can have in guiding staff in thinking about child protection cases.

In both stages of the research, the professionals that respondents stated they would discuss the case with were colleagues, manager, child protection advisor, senior partner, supervisor and Social Services. Responses from social workers mainly indicated they would discuss the case with their manager, GPs responded that they would discuss the case with colleagues or senior partner. In stating they would

discuss with a colleague, this included paediatrician, GP colleague and health visitor but did not include social workers or school nurses despite the fact the scenario involved a school age child. These findings reflect the findings of the research undertaken by Tompsett et al (2009), in which half the GPs expressed a preference for seeking early advice and support from a paediatrician or other health colleague, rather than children's social care services and two thirds of GPs rated the health visitor as highly significant to refer to. In this study, health visitors and school nurses responded that they would discuss the case with colleagues, social workers, supervisor or the child protection advisor.

Participants were asked whether they would attempt to find out the children's status on the child protection register. There was a wide range of responses. In the pre-Laming questionnaire, in response, 97% of social workers, 68% of health visitors, 64% of school nurses and only 9% of GPs stated they would attempt to find out the children's status on the child protection register. There was little difference in response between professionals working in borough 1, where the response was 51% and borough 2, where the response was 52% overall. In the post-Laming questionnaire, there was an increase in respondents who would check whether the children were subject to a plan. 100% of social workers, school nurses and health visitors responded that they would check and 30% of GPs responded they would check. There was a response rate of 87% in borough 1 and 77% response rate in borough 2 of those who stated that they would check whether the children were subject to a plan.

Participants were asked to consider whether they believed the threshold had been reached where a child protection conference should be called. Once again, there was a variation in response in both the pre and post-Laming stages. In the pre-Laming stage, no social worker or school nurse believed the threshold had been reached, compared to 6% of GPs and 18% of health visitors. In the post-Laming stage, no social worker believed the threshold had been reached, compared to 8% of health visitors, 6% of school nurses and 7% of GPs. It is unclear why the changes took place between the pre and post-Laming stage, but the increase in school nurses believing the threshold had been met may be in response to Victoria

Climbié being a school aged child. In terms of the two boroughs, in the pre-Laming stage 4% working in borough 1 believed the threshold had been reached compared to 14% in borough 2 and in the post-Laming stage 4% in borough 1 compared to 6% in borough 2. Given the low numbers generally who stated that they believed the threshold had been met for a child protection conference the differences across the two boroughs may not be significant but it is possible that the change in responses in borough 2 between stages 4 and 5 could be resource driven and perhaps shows a change in the thresholds between the pre and post-Laming period.

Participants were asked to indicate whether they would attend a child protection conference if a conference were held. In response, in the pre-Laming stage, 94% of social workers stated they would attend; the 6% who stated they would not attend were senior social workers, which mean they may not be required to attend. 100% of school nurses, 73% of health visitors and only 14% of GPs stated they would attend. In borough 1 54% stated they would attend a child protection conference compared to 60% in borough 2. In the post-Laming stage, 100% of social workers, health visitors and school nurses stated they would attend, compared to 24% of GPs. 83% of respondents said they would attend in borough 1 compared to 78% in borough 2. In the pre-Laming questionnaire it was surprising that only 73% of health visitors stated they would attend, given that one of the subjects is a baby. The low percentage of GPs who indicated they would attend reflects the findings of other research studies (Tompsett et al 2009). GPs as independent contractors run their practices as businesses and therefore issues that impact upon their commitment to attendance at conferences include time, inconvenience and distance (Tompsett et al 2009).

Participants were asked to consider what they perceived their role to be in terms of the case scenario, with options given from a set menu. Responses are given in tables 8.12, 8.13, 8.14 and 8.15.

Table 8.12 – Professional roles in pre-Laming stage

	Receiving information (%)	Sharing information (%)	Joint planning (%)	Giving expert opinion (%)
GP	100	97	30	10
Social Worker	92	89	62	36
Health Visitor	69	97	68	66
School Nurse	100	100	73	64

Table 8.13– Professional roles in post-Laming stage

	Receiving information (%)	Sharing information (%)	Joint planning (%)	Giving expert opinion (%)
GP	100	84	22	18
Social Worker	100	80	78	28
Health Visitor	62	100	82	72
School Nurse	98	100	62	53

Emphasis across professional disciplines differed in whether they felt the emphasis of their role was receiving or sharing information. There is less emphasis for social workers to share information than receive. This could be linked to their role as lead professional where the expectation is that the information would be shared with them to undertake their role. There were also a relatively low percentage of social workers who saw their role as giving expert opinions. It may be that although social workers are the lead professional, they view specific information eg health information as "expert" as opposed to their own safeguarding knowledge.

In order for collaborative working to be effective, joint planning is a key stage of the safeguarding continuum. However, the study showed a low response to this

from GPs in the pre and post-Laming stage, from social workers and health visitors in the pre-Laming stage and from school nurses in the post-Laming stage.

Table 8.14 – Professional roles in pre-Laming stage

	Jointly discussing (%)	Maintain liaison (%)	Joint planning separate interventions (%)	Joint action (%)
GP	72	81	6	34
Social Worker	86	89	30	41
Health Visitor	70	86	68	63
School Nurse	45	73	45	27

Table 8.15 - Professional roles in post-Laming stage

	Jointly discussing (%)	Maintain liaison (%)	Joint planning separate interventions (%)	Joint action (%)
GP	56	43	2	12
Social Worker	82	83	33	48
Health Visitor	78	93	66	72
School Nurse	53	88	33	18

Interestingly, the percentage of GPs who perceived they had a role in relation to joint discussion, maintaining liaison, joint planning separate interventions and joint actions was lower in the post-Laming stage compared to the pre-Laming stage. There was also a lower percentage of GPs who considered they had a role at each of these stages in comparison to the other three professional groups. It may be that GPs, as independent contractors, have not had the same degree of scrutiny in terms

of safeguarding governance, including training uptake as other professionals in the post-Laming period. The responses of health visitors and social workers showed minor variation in the post-Laming stage compared to the pre-Laming stage.

Further information relevant to the scenario was presented to participants. The information given at this stage was that the mother had a mild learning disability and was suffering with depression. The baby's weight was on the 4th centile. The 6 year old had poor school attendance and was reported as being aggressive to other children when in school. The baby had a small bruise on the right cheek.

Participants were asked to state whether they would take action in light of this additional information. In responses in the pre-Laming stage, there was consistency amongst the three categories of health professionals with a hundred per cent stating they would take action. In comparison, 97% of social workers stated they would take action. The 3% whose response indicated they would not take action did not indicate the reason for that decision. The response rate in terms of respondents stating they would take action was 99% in borough 1 and 100% in borough 2 in the pre-Laming stage. In the post-Laming stage, 100% of each professional group responded that they would take action.

The actions professionals stated they would take in both the pre and post-Laming stages were varied according to discipline. Social workers stated they would hold a strategy meeting/discussion or undertake a joint investigation with the police. Health professionals' responses varied from "assess the bruise" to "offer a support package" to "refer to social services".

Participants were asked whether they would discuss the case at this stage. The highest rate in the pre-Laming stage was from social workers, with 97% stating they would discuss the case. 82% of school nurses, 85% of health visitors and 71% of GPs stated they would discuss the case. In the post-Laming stage, 100% of social workers, 92% of health visitors, 90% of school nurses and 60% of GPs responded that they would discuss the case. In the post-Laming stage, the percentage of GPs that responded they would discuss the case was lower than the pre-Laming stage, whereas for the other professional groups the percentage had

increased. Once again, there was a significant difference in response from professionals working in the two boroughs, with 74% in borough 1 in the pre-Laming stage compared to 91% in borough 2 and in the post-Laming stage 76% in borough 1 and 89% in borough 2. The reason given by health visitors, school nurses and social workers for not discussing the case was that they would have discussed the case at an earlier stage. In the case of GPs, where a lower number stated they would discuss the case, this may reflect professional arrangements, in that supervision for social workers, health visitors and school nurses is compulsory, whereas this is not common practice in relation to child protection for GPs. Neither borough at the time of the pre-Laming stage, in line with many other areas nationally, had a named GP for child protection. Currently, named GPs for child protection are in post more widely.

In common with the previous response, the professionals whom respondents stated they would discuss the case with were colleagues, manager, child protection advisor, senior partner and social services. In addition, several social workers stated they would discuss the case with the police and a number stated they would discuss the case with an advocacy service for clients with a learning difficulty.

Participants were asked whether, given the information that was now available to them, they would attempt to find out the children's status on the child protection register. In both the pre and post-Laming stages, there was a significant increase across professional disciplines in respondents stating they would attempt to find out the status of the children on the child protection register. In the pre-Laming stage, 100% of social workers stated they would check the child protection register compared to 82% of school nurses, 80% of health visitors and 44% of GPs. In the post-Laming stage, 100% of social workers, school nurses and health visitors and 48% of GPs stated they would ascertain whether the children were subject to a child protection plan.

Where professionals' responses indicated they would not check the child protection register, the reason most commonly stated by school nurses and health visitors in the pre-Laming stage was that they would already have checked the

register or they would know the child protection registration status. In the case of GPs, several stated that they would expect other professionals to have done this and in the case of one respondent they stated they were unaware of the route to check the register. This reflects a training issue and to date at a national level safeguarding children training is not compulsory for GPs. The reasons for not attending such training may reflect the same reasons as not attending child protection conferences which includes time, inconvenience and distance. In addition, as generic practitioners, safeguarding children training is viewed by GPs as one area amongst many that they are encouraged to attend, with a number of other training topics being aspects that they are exposed to far more frequently in practice. Another issue for health professionals is that 24 hour access to the child protection register was limited at the time the research was in progress, with no electronic access, although there is evidence that, even with access, professionals do not always use it (Commission for Health Improvement 2003). Consulting the child protection register is likely to improve when staff members are trained and their awareness about child protection issues raised.

Participants were then given further information stating that in the case described in the scenario the decision is made to hold a child protection conference. Further information was given in relation to the scenario indicating issues of financial debt, rent arrears with the possibility of eviction, maternal depression resulting in the needs of the children not being met, issues regarding lack of food in the home, children witnessing domestic abuse and concerns about the school aged child's health and education needs not being met. Participants were asked, in an open question, to list the professionals they would expect to attend the conference. The responses are given in Table 8.16.

Table 8.16 - Professionals expected to attend child protection conference

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Social Worker	169	98.8	168	100
Social Work Manager	34	19.8	62	36.9
GP	12	7	64	38
Health Visitor	160	93.5	164	97.6
School Nurse	82	47.9	77	45.8
Health Manager	28	16.3	12	7.1
Adult Services	16	9.3	22	13
Police	31	18.1	62	36.9
Paediatrician	28	16.3	33	19.6

In considering the responses in both the pre- and post-Laming stages there was recognition of some of the professionals that would routinely be invited, including the social worker and health visitor. Interestingly, the percentage of respondents that expected the police, the school nurse and adult services to be invited were relatively low and yet, given the information provided these professionals would almost certainly be invited. The most significant increase between the pre- and post-Laming stages was in relation to GP attendance, although this remained relatively low. The reason for the low responses may be respondents' experience, in practice, of professional groups, who, although invited, may fail to attend.

Participants were asked whether they believed the threshold for child protection registration had been reached for each child. In the pre-Laming, stage 80% of social workers stated the threshold had been met for both the three month old and six year old. 80% of health visitors stated the threshold had been reached in the case of the three-month-old compared to 72% in the case of the six year old. 82% of school nurses stated the threshold had been met for registration of the three-

month-old and 55% in the case of the six year old. 92% of GPs stated the threshold had been met for the three month old child but only 54% believed the threshold had been met for the six year old. There was a small difference between professionals working in each of the boroughs, with 83% of respondents in borough 1 compared to 84.5% in borough 2 stating the threshold for registration had been met for the three month old. In the case of the six-year-old child 64% in borough 1 stated the threshold for registration had been met compared to 68% in borough 2. In the post-Laming stage 100% of social workers and health visitors stated the threshold had been met for registration for the three month old compared to 88% of school nurses and 92% of GPs. In assessing the six year old, 80% of social workers, 68% of health visitors, 58% of school nurses and 52% of GPs stated the threshold had been met. In borough 1 93% of the respondents compared to 97% in borough 2 stated the threshold for registration had been met for the three month old and for the six year old, 60% in borough 1 and 69% in borough 2. It is interesting to note that the rates of children subject to a plan were lower in borough 2 than borough 1 at the time this research project began and yet, in assessing this scenario, a higher number of respondents in borough 2 assessed that the threshold for registration had been met. It is possible that post-Laming borough 2 participants' responses were reflecting a reduction in social care resources and perhaps a reduction in confidence that action would be taken by social care, despite recognising the level of concern themselves.

Participants were asked to consider the role of a range of professionals in contributing to a child protection plan. The results are given in table 8.17.

Table 8.17 – Professionals' views as to which professionals should contribute to a child protection plan

	Pre-Laming		Post-Laming	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Social Worker	170	99.4	168	100
Health Visitor	167	97.6	168	100
Teachers	29	16.9	28	17
School Nurse	98	57.3	91	54
GP	12	7	8	5
Paediatrician	19	11.1	11	6
Psychiatrist	7	4	12	7
Psychologist	2	1.1	4	2
CPN	11	6.4	18	11
Community Learning Disability Team	18	10.5	29	17
Accident and Emergency	2	1.1	0	0
Education Welfare Officer	43	25.1	4	2
Police	13	7.6	12	7
Family Members	62	36.2	88	52
Advocacy Service	9	5.2	7	4

In considering the responses in both the pre and post-Laming stages there is recognition that the social worker and health visitor should contribute to the child protection plan. In relation to the six year old, approximately half the respondents identified the school nurse as contributing and only 17% recognised the teacher's contribution. These findings are surprising, given that in the biennial analysis of

serious case reviews 2005-2007, 37% of the children were aged 4 and above (Brandon et al 2009), which emphasises the need to be alert to the needs of the school aged population. A very small percentage considered the role of the education welfare officer, despite the concerns around school attendance for the six year old. In the post-Laming stage, there was an increase in respondents recognising the importance of family members contributing to the child protection plan and despite the issues at the level of the adult family member's, there were relatively low numbers of respondents who recognised the contribution of the adult focused services or the advocacy service.

8.6 Collaborative working to safeguard children

The findings of the section of the questionnaire that used two open questions to explore the experience of multi agency working between professionals working in the two boroughs will now be presented. The first question asked participants to reflect on the extent to which a multi-agency approach was adopted in their work setting, when working with children in need of services and, secondly, when working with children in need of protection. This type of questioning was used to elicit qualitative data by allowing respondents to answer in any way they wished, either briefly or at length. Such open-ended questions assume that the respondent has feelings, recollections or views on the topics addressed. The aim of this approach was to gain understanding from the participants' frame of reference.

Various authors have suggested a variety of analytical frameworks for use in data analysis. Some authors have focused on the importance of analysis as primarily a task of manipulating data through processes of coding, indexing, sorting and retrieving. This prospective approach to analysis is viewed in terms of data handling, making the procedures of organisation and retrieval paramount (Dey 1993, Wolcott 1994, Miles and Huberman 1994). Other authors have focused on the importance of imagination and interpretation, with the procedural and categorising task such as sorting the data seen as the preliminary work (Coffey and Atkinson1996). The author of the current research project supports the latter approach.

For this part of the study, the data generated was from only two questions and therefore the analysis of data was less complex than the use of qualitative approaches for the whole study, which would have generated considerably more data to analyse. The approach to data analysis at this stage was the maintenance of systematic indexing, in which subjects that recurred were entered on a simple spreadsheet to allow themes and concepts to be focused upon. The responses were coded to distinguish between a respondent's professional role and the borough in which they work.

In analysing the responses, a number of themes emerged. They were common to both areas under exploration, namely children in need of services and children in need of protection. The results will be presented in headings that reflect the emerging themes.

Tables 8.18 and 8.19 give the responses across the two boroughs indicating whether respondents felt a multi-agency approach to children in need and children in need of protection was adopted.

Table 8.18 - The extent to which a multi-agency approach for children in need was believed to be adopted

	Pre-Laming			Post-Laming	
	Frequency	Percentage		Frequency	Percentage
Borough 1	38	22		58	35
Borough 2	158	92		160	95

Table 8.19 - The extent to which a multi-agency approach for children in need of protection was believed to be adopted

	Pre-Laming			Post-Laming	
	Frequency	Percentage		Frequency	Percentage
Borough 1	167	98		168	100
Borough 2	138	81		122	73

The findings as stated in the above tables clearly indicate that a considerably higher number of participants working in borough 2 believe a multi agency approach is adopted for children in need of services in both the pre and post-Laming stages, compared to participants working in borough 1. The higher response rate in borough 2 relating to the existence of multi-agency approaches for children in need of services may be the result of the child in need policy being put into practice, whereas the policy for children in need in borough 1 was not developed at the time the current research commenced.

In analysing, the data generated from the questionnaires in both the pre and post-Laming stages, there were broadly four themes that emerged and the response rates are detailed in Table 8.20. The rates in the table indicate the number of respondents that identified the theme, whether it was viewed as a negative or positive factor. Further analysis of those responses is detailed in the text that follows.

Table 8.20 – Factors identified by respondents evidencing positive or negative experience of multi-agency working

	Pre-Laming		Post-Laming	
	Frequency	Percentage	Frequency	Percentage
Communication as a positive experience	68	40	92	55
Communication as a negative experience	98	57	54	32
Cooperation as a positive experience	90	53	97	58
Cooperation as a negative experience	102	60	53	31
Role friction	62	36	44	26
Occupational status	48	28	23	14
Emotional impact of safeguarding work	77	45	93	56

In the pre-Laming stage there were 545 responses from 171 respondents and in the post-Laming stage 456 responses from 168 respondents.

8.7 Communication

Issues of communication have been a constant feature in inquiry reports, with social workers and health visitors being particularly vulnerable to criticism for non-compliance in aspects of communication and information sharing (Hallett 1989).

Communication was the theme referred to by the second highest number of respondents in the pre and post-Laming stages. Overall, respondents in borough 2 reported communication to be more positive, whereas in borough 1 communication was the theme referred to most frequently by respondents as a key obstacle to effective multi-agency working. Health visitors and school nurses were more likely to report positive experiences of communication both when working with children in need and children in need of protection compared to GPs and social workers; however, there were more negative comments by those disciplines working in borough 1 in comparison to borough 2. There were also a number of respondents who, despite reporting positive communication within their own agency, reported negative experiences of communications with the other agency.

One school nurse working in borough 1 responded:

> "We liaise well within health including a wide range of therapists but we get no feedback from social services unless we chase it"

A response from a social worker in the same borough was:

> "I would value more communication from doctors when children are on the register"

A GP working in borough 1 commented in a similar way but in relation to social workers:

> "Although this (child protection) generally works better other than updating information the two agencies rarely communicate. I would expect the social worker to keep others updated."

The same perception was featured to a lesser extent in answers from respondents in borough 2, where the responses on the whole indicated communication to be satisfactory. One school nurse commented:

> "Communication works well within our agency and across agencies. It is well developed for child protection and children in need and on the whole multi agency working works well"

The more positive response in borough 2 in comparison to borough 1 may be influenced by the multi agency system developed across the systems for both children in need and children in need of protection.

A social worker in borough 2 commented:

> "Communication works well within my agency and with a range of health professionals and I routinely receive updates from the health teams following contact with the family"

Information sharing is an important aspect of communication and has been identified as an area of concern recurrently in the analysis of serious case reviews (Brandon et al 1999, Brandon et al 2008, Brandon et al 2009). Particular areas of difficulty highlighted reflect national findings and lie in the concerns of different professionals about the legality of sharing confidential information with others and in particular raise issues around the potential impact on the confidentiality of relationships between themselves and their client or patient. These issues have become more complex with the interpretation by different professionals of the Data Protection Act 1998 and the Human Rights Act 1998, which often act as a barrier to information sharing (Department for Education and Skills 2004).

Research has suggested that nurses and other health professionals do not communicate effectively (Hallstrom et al 2002) and this is reinforced in analysing the range of complaints received by NHS bodies, where the highest proportion relate directly to issues of communication (Pinnock 2004). In the Laming Report, (2003) the overarching message is the need for professionals to be more proactive in gathering and sharing information. The same messages are highlighted in the Bichard Inquiry (2004).

Communication involves displaying openness to the views of others and involves consulting and engaging others, an essential element of collaborative working being achieved. It also relates to other key themes that emerged from the analysis of the responses, including role friction and, a key element of that friction, trust.

8.8 Cooperation

The wealth of literature that considers collaboration as discussed in chapter 3, frequently distinguishes between collaboration and cooperation. The theme of cooperation was evident in the responses across the continuum of children in need and children in need of protection. Although health professionals are not a homogenous group, with identity and boundary issues existing within the different professions, the boundary issues were more apparent in responses made between health and social care.

A GP working in borough 1 demonstrated such perception:

> **"**There appears to be a barrier between health and social services"

This was reinforced by a health visitor and school nurse working in the same borough. The health visitor stated:

> "Social workers expect a high level of cooperation from health but rarely respect their views"

This reflected a similar perception to that of the school nurse, who stated:

> "I feel health and social services operate following their own agency procedures and lack a cohesive approach"

There were more positive responses from participants working in borough 2 and a number of respondents in borough 2 believed that the multi-agency assessment process had improved cooperation between agencies. A social worker in borough 2 stated:

> "The Assessment Framework promotes good cooperation. In using the framework to assess families it ensures the contribution of all professionals is valued. This has really improved practice in this area"

Joint assessment initiatives may provide a bridge for communication and cooperation between professional disciplines working with children and their families, but there is still the need to develop a "communication mind set".

The positive responses from participants working in borough 2 were particularly evident in those that related to the adoption of a coordinated approach in response to children in need of services. A social worker working in borough 2 stated:

> "There is a formal system for child in need meetings which helps achieve a really positive outcome"

The experience of the multi-agency approach to children in need was also viewed as positive by health professionals and a typical response was that of a school nurse working in borough 2:

> "We frequently participate in child in need meetings and feel our contribution is valued"

In borough 1, the reason for the dissatisfaction with the multi-agency response to children in need was viewed by a number of respondents to be that resources were inadequate. A health visitor working in borough 1 stated:

> "Facilities don't exist in social services to act in a preventative role"

This view was shared by other disciplines and a GP stated:

> "During a crisis multi-agency working is good however, there is little cooperation to prevent crisis"

Respondents in borough 1 generally felt there was an improved response, where there were clear child protection concerns. The response from a health visitor working in borough 1 was reinforced by a number of other respondents:

> "The multi-agency approach seems to work better with child protection"

There were, however, concerns expressed that the level of commitment was not the same throughout the different stages of the process. The comments of two social workers both working in borough 1 evidence such views:

> "Once the initial conference is over it can be difficult to keep other agencies on board"

> "Often other agencies "drop away" leaving social services in charge of planning, implementing, monitoring, reviewing and evaluating"

Macdonald and Williamson (2002) examined the range of support services for children and families and emphasise the need for organisations to address structural problems that stand in the way of providing a response to prevention, to ensure the evidencing of accountability in the wider safeguarding field.

A British literature review of cooperation between primary health care and social work identified a range of personal qualities, including commitment and the need for shared goals (Corney 1988). There is widespread agreement in the literature that working together is difficult and a number of authors report on the difficulties achieving coordination (Challis et al 1988, Blyth and Milner1990). The reasons for this have been explored in Chapter 3. Hallett (1995) found in her research evidence of a clear division of labour in child protection work and, further, in line with the views expressed by some participants in the current study, she revealed a child protection system severely constrained by resources. It is acknowledged that the research undertaken by Hallett was published 15 years ago, and although the recent rise in the profile of safeguarding may have resulted in the breaking down of some of the divisions, financial restraints remain an issue.

8.9 Role friction and occupational status

Personal and occupational values and agency functions are interwoven strands of considerable complexity. Conflict and confusion over expectations of the roles of others have been noted in a number of older studies (Sheppard 1980, Dingwall 1980, Bond et al 1985).

In the current research study, there were examples from respondents of personal qualities, which served to enhance or hinder joint working.

In borough 1 a typical example from a health visitor was:

> "Social workers have often been unhelpful"

Another health visitor working in the same borough reinforces the fact that qualities at the level of the individual are important in promoting effective working across agencies.

> "The extent of multi-agency working depends so much on which worker is involved"

In achieving effective collaboration, a number of authors have acknowledged the personal component and the importance of a number of personal qualities. The personal qualities identified include: openness, sharing, mutual integrity, democracy, non-hierarchy, flexibility, trust, mutual respect, ability to deal with feelings constructively, supportiveness, assertiveness, self confidence, respect for others, personal status as distinct from professional, safe but stimulating interactions, capacity for conflict resolution, a search for consensus or healthy means of coping with conflict, collaborative values and shared goals (Mundie 1984, Bross et al 1984).

Within the literature reviewed, a number of authors have identified occupational status as an issue that may impact upon collaboration being achieved. Webb and Hobdell (1980) note traditional status factors belonging to doctors. The same issues were identified several years later by Hallett (1995) who concluded that the mandate to work together is not widely accepted by GPs, who may have the status and independence to ignore it. Howe (1986) argues that status derives from not only the complexity of knowledge but the value of the material handled. Medicine in the eyes of a number of professionals and the public has held a high degree of status.

Within the current study, the issue of occupational status was evident. A school nurse working in borough 2 stated:

> "It is more difficult when a child is registered as social services very much dictate"

This apparent professional dissatisfaction with the professional hierarchy was apparent from a number of respondents, with social workers seen as the profession "in charge". A health visitor working in borough 1 stated:

> "The whole process is based on the convenience of the social worker; the dates of meetings are always set around the social worker's availability"

A different perspective can be seen when considering the response from one social worker working in borough 1, which reflected responses from a number of other social workers:

> "When the crunch comes it always seems to be down to social services"

This view was reinforced with a response from a GP working in borough 2, when referring to work with children in need of services:

> "I feel as a GP my contribution can only be on paper because of work pressures in other areas"

Jones et al (2002) identified a number of barriers to successful collaboration in safeguarding work. The barriers identified include: Variation in the socialisation of different professional groups; lack of understanding of the roles of other professionals; perceived status differences and role competition between professionals; differences in orientation, vocabulary and working style and concerns regarding loss of professional autonomy and professional domain. Barriers relating to status, autonomy and professional domain may be exacerbated by threats regarding possible erosion of professional expertise and the dilution of professional skills as a result of collaboration.

The framework, presented by Morrison (2000), is helpful in understanding intra and inter-agency relationships. In his framework, Morrison describes four types of inter-agency relationship: Paternalistic; adversarial; play fair and therapeutic/developmental. In the current research, some responses reflected a paternalistic culture, which Morrison describes as placing emphasis on hierarchy at the expense of negotiation. Within such a culture, the agency views itself as having

unique expertise and finds it hard to respect or involve others, who often offer a range of different skills.

The "Top-down" approach to reform in the practice of safeguarding children in recent years has focused on policy, targets and inspection and scrutiny, as discussed in earlier chapters. This approach overlooks the importance of the individuals working in the different organisations, and as a result promotes professional tensions, rather than the successful implementation of collaborative approaches. This policy and target driven approach can, in turn result in professional stress, which may further mitigate against the achievement of professionals working well together.

8.10 Emotional impact

In analysing responses in the current study a theme that was very evident was the extent to which the emotional impact of safeguarding work impacts upon the extent to which collaboration can be achieved. This was an aspect that the researcher had not expected to emerge, despite the fact that she is an experienced practitioner in this area of practice. This raises questions as to whether this important aspect is overlooked in services that employ practitioners, where safeguarding work is a key component of their role. In considering responses from the participants, it was clear that child protection work raised a range of emotions in professionals, including fear and anxiety. This was more evident in respondents' views that relate to the area of child protection compared to the area of the child in need. The following response from a social worker working in borough 2 was typical of other responses relating to children in need:

> "There is far less anxiety, working with this group as risks are lower"

The response from a social worker working in borough 2 is typical of others when relating their experience of working with children in need of protection:

> "Often stress working in this area gets in the way of good interagency working"

A social worker working in borough 1 gave a similar response:

"Professionals feel the need to cover their backs so often appear defensive"

The need for management recognition of the stress that results from this area of practice was raised by a number of respondents across disciplines. One health visitor working in borough 2 stated:

"More support is needed from management"

Two respondents in borough 1, a health visitor and school nurse referred to the pressure from the high levels of scrutiny from within the agency and from processes externally.
A school nurse working in borough 1 reinforced the feeling of isolation:

"The process makes you feel as though you are on your own"

The issue of the impact of this area of work on the professional appears to be one to which insufficient attention has been paid. Mayhall and Norgard (1983) identified the varied reactions that child abuse work evokes amongst staff and the fact that these may act as intrinsic barriers to adopting a joined up approach. It is recognised that different professions are unequally prepared for the stress this work can evoke. The impact of such stress can lead to inappropriate decision making (Copans et al 1979).

Although it is recognised that the stress of child protection work can be a barrier to collaboration, collaboration may also be viewed as the solution. Peer support has been advocated by a number of authors over time (Drews 1980, Fryer et al 1988). Dale et al (1986) clearly stated that for professionals working with cases of sexual abuse, teamwork actually resulted in obviating burnout by:

"Stimulating intellectual and therapeutic creativity" resulting in work becoming an "exciting and a stimulating place to be" (Dale et al 1986:208)

8.11 The influence of the Laming inquiry in changing practice for children in need and children in need of protection

Stage 5 of the research included the use of three additional questions in the postal questionnaire to ascertain whether in the experience of respondents the Laming Inquiry had resulted in changes at a local level in the way health and social care professionals work together with both children in need of services and children in need of protection. If the respondent indicated the Laming Inquiry had resulted in changes, respondents were asked to indicate what changes had taken place. The responses are given in Tables 8.21 and 8.22. Respondents were also asked to indicate factors that promote effective collaborative working between health and social care. The responses are given in Table 8.23.

Table 8.21 – Whether respondents feel the Laming inquiry has impacted on collaborative work between health and social care for children in need Of Services and protection

	Children in Need			Children in Need of Protection	
	Frequency	Percentage		Frequency	Percentage
Yes	158	94		166	99
No	10	6		2	1

As would be expected, the majority of respondents believed the Laming Inquiry had impacted on collaboration in both areas of practice, children in need of services and children in need of protection. The number that felt it had impacted on practice where children are in need of protection were marginally higher compared to children in need of services.

Table 8.22 - Ways in which working between health and social care professionals has changed as a result of the Laming inquiry

	Frequency	Percentage
Use of Common Assessment Framework	15	9
Improved joint working	64	38
Improved information sharing	62	37
Greater understanding of shared responsibility	14	8
Improved multiagency training	33	20
Improved child protection plans	21	12
Joint visits	39	23
Improved communication from safeguarding board	18	11
Better understanding of thresholds across agencies	54	32
Joint audits	4	2
Supportive networks across agency improved	7	4
Clearer multi agency procedures	12	7

In analysing the responses, the areas that the greatest number of respondents identified as improving as a result of the Laming Inquiry were improved joint working, improved information sharing and understanding of thresholds. Areas of joint working practice were also identified, including joint visits, joint audits, improved multi agency procedures and improved multi agency training. In addition to the changes that were seen as positive, a number of concerns were raised in terms of experiences that respondents viewed as negative consequences as a result of the Laming Inquiry. The main concerns identified were:

- Lack of increased funding to meet increased demands
- Need to develop preventative work alongside protection with increased training attendance requirements but no increase in funding or staff
- Increased scrutiny "feels like a blame culture"
- GPs still not held to account

- Increased paper work
- So much bureaucracy
- Constant change and restructuring

8.12 Factors that promote effective collaboration between health and social care

Given the number of policy initiatives resulting in structural changes based on collaborative working practices, including Children's Trusts, the implementation of information, referral and tracking systems and the implementation of the Integrated Children's System greater understanding is needed of the factors that enhance successful collaborative working. Table 8.24 lists the main factors that were identified by respondents that in their experience enhance or inhibit collaborative working both with children in need and children in need of protection.

Respondents in stage 5 of the research were asked an open question to identify factors that they believed promote effective collaborative working between health and social care professionals in work to safeguard children. The responses are detailed in Table 8.23.

Table 8.23 - Factors that promote effective collaboration between health and social care

	Frequency	Percentage
Shared thresholds	54	32
Informal joint meetings	53	31
Joint training	44	26
Joint assessment	44	26
Clarity of roles	30	18
Joint risk assessment	21	13
Coterminous boundaries of professional teams	21	13
Co-location	18	10
Shared procedures	11	7
Jointly funded posts	6	3
Understanding of different organisational cultures	6	3
Pooled budgets	4	2

A number of the factors identified by respondents that were deemed to promote effective collaboration were factors that respondents had identified as improving

since the publication of the Laming Inquiry in 2003. The factor identified by the greatest number of respondents was shared thresholds and this has been discussed in chapter 4. The factor identified by the second greatest number of respondents was the practice of informal joint meetings. At a time where changes to structures and boundaries across a number of agencies are a constant feature the opportunities for such practices should not be lost. The practices of joint assessment and joint training were identified by several respondents as promoting effective collaboration. These findings reflect national evaluation studies of collaborative initiatives such as Sure Start and the Children's Fund Prevention Programme (Mason et al 2005, Tunstill and Allnock 2007).

8.13 Conclusion

In analysing the responses from participants across health and social care, a number of important themes have emerged in terms of the extent to which the professionals practising within two health and local authorities perceived a collaborative approach was adopted between the two agencies when working both with families where there were children in need of services and families where there were children in need of protection. A range of factors that may enhance or inhibit collaboration were identified, including shared thresholds, the practice of informal joint meetings, joint assessment and joint training. The responses to the vignettes demonstrated different levels of professional participation in work, both with children in need and at different stages of the process for children in need of protection. There was lack of consensus in several of the cases in terms of thresholds of concern; the differences in thresholds were in relation to different types of abuse and differences between professional groups and the two boroughs. There were also differences in the application of thresholds in the pre and post-Laming stages. A finding that the researcher believed to be significant was the finding from the research that indicates that a considerably higher number of participants working in borough 2 believed a multi agency approach is adopted in work where there are children in need of services in both the pre and post-Laming stages, compared to participants working in borough 1. This may relate to the existence of multi-agency approaches for children in need of services and the practice of professionals within borough 2 implementing that child in need policy.

As would be expected, the majority of respondents believed the Laming Inquiry had impacted on collaboration in both areas of practice, children in need of services and children in need of protection. The numbers that felt it had impacted on practice where children are in need of protection were marginally higher compared to children in need of services. In analysing responses in the current study, a theme that was very evident was the extent to which the emotional impact of safeguarding work impacts upon the extent to which collaboration can be achieved. This is worthy of further investigation in the form of future research. The findings from the research will be further discussed in chapter 9.

CHAPTER 9
Conclusions

9.1 Introduction

In this chapter, the conclusions of the study are presented. The current study is a study of local policy and practice before and after a landmark publication (Laming 2003). It is also a study of two boroughs with similar population characteristics but (pre-Laming), different approaches to the provision of services for children in need. The study explored collaborative working between health and social services professionals when working both with families where there were children in need of services, and families where there were children in need of protection. Comparison is made of practice in the period before the 2003 Laming report to that following the report's publication. The study was undertaken across two London boroughs, using a case study approach. The main data sources were the safeguarding children policy and procedural documents available in the research sites, child protection management information data and questionnaires issued to health and social care professionals, using a series of vignettes, developed from real life cases. The study sought to relate the findings to a broad range of literature on collaborative working in the practice of safeguarding children.

In the literature reviewed collaboration and a range of associated terms are often used inter-changeably, and at times are used within the same paragraph or even sentence. In undertaking a review of the literature for the current, study it can be seen that much use of the terminology is policy driven, giving way to the use of terms such as 'joined-up thinking' and 'joined-up working'; an example of this is Every Child Matters (DfES 2004: 9) which states that progress in improving educational achievement for children and young people in care and in improving their health has been possible through better joint working.

The findings of this research reveal a number of important themes in terms of the extent to which, the professionals practising within two health and local authorities, perceived a collaborative approach was adopted between the two

agencies when working both with families where there were children in need of services and families where there were children in need of protection. The findings from this research do not always concur with the political vision, which views collaboration purely from a positive perspective and has seen policy as a route to achieving this in practice. From the current research, a range of factors that may enhance or inhibit collaboration were identified. In this chapter, a critical assessment of the results is presented to demonstrate how the objectives of the research have been achieved. Limitations of the research are acknowledged and areas identified that warrant further investigation are stated.

9.2 Children in need to children in need of protection the continuum

The research considered collaborative working across the continuum of children in need of services through to children in need of protection. While child protection work has an established body of research and an increasing knowledge base which informs its practice, far less attention has been paid to the practice issues associated with children identified as being 'in need' as defined by section 17 of the 1989 Children's Act. Given that all children coming to the attention of local authority children's services are, in fact, 'children in need' (Parton 2007), this seems surprising. Within the current research, at the time the research commenced, one of the two boroughs had an established multi-agency child in need policy with a multi-agency practice response.

Professionals who participated in the research applied different thresholds of concern, in making judgements, in terms of the cases presented that describe children in need of services. There was a lack of consensus between the two boroughs and between different professionals. The lack of consensus has been found in a number of research studies (Hallett and Stevenson 1980, Dingwall et al 1983, Dale et al 1986, Corby 1987). Interestingly the lack of consensus has remained unchanged over time, having been identified by Hallett and Stevenson in 1980 and being a finding in both stages 4 and 5 of the current study. The research findings demonstrated respondents in borough 2 consistently assessed the scenarios that related to children in need as more serious than professionals in borough 1 in both the pre and post-Laming surveys. The experience of professionals working in borough 2, of working in a multi-agency environment

when providing services for children in need may have contributed to the different assessment of the scenarios within the vignettes.

The two boroughs used in the research were specifically chosen for inclusion. At the time the research commenced, the two boroughs were very similar in terms of demography and levels of deprivation, and yet had very different rates of children, subject to a child protection plan. It is possible that if thresholds in borough 2 were lower and there was a well-established multi-agency approach to meeting the needs of children in need, before they reached the threshold of significant harm, this process may be a significant contributory factor in the lower rates of child protection registration in the borough

Within the research there were also differences in the assessments by different professions, of the vignettes relating to children in need. There may be a range of reasons for the differences between the different professions. The degree of exposure that professionals have had to this area of practice is likely to affect their confidence in assessment practice with this group of children and young people. GPs have very limited input with children in need, other than the provision of medical services, which may affect their ability to apply thresholds consistently. Wolstenholme et al (2008), state that when working with children in need, the complexity of needs and diversity of experience compound the challenge faced by practitioners.

Shifting the dominant paradigm within child safeguarding from child protection to the inclusion of children in need has been a challenge for multi-agency practice for a number of years and was discussed in chapter 2. In order to shift the balance from a culture of reactionary safeguarding to earlier intervention, different multi-agency arrangements will need to be considered. The significant number of policy changes during the time the research has been in progress, has resulted in a move towards professionals being required to focus on children's welfare needs, rather than child protection. The need for a more holistic focus has not been supported with additional funding, and has therefore resulted in thresholds being shifted to respond to budgetary pressures (Barlow and Scott 2010).

9.3 The different levels of collaboration throughout the case career

Chapter 1 describes how the child protection system may be envisaged as an individual case career following six sequential stages. A clear finding in this study was that the level, intensity and spread of interagency involvement are not consistent across the range of stages of the safeguarding continuum. This was even more evident in the work with children in need of services as opposed to children in need of protection. Interagency working was better established in child protection work up to and including the stage at which the child protection conference took place. In the pre-Laming stage, there were marked differences between GPs and other professional groups stating whether they would attend child protection conferences. In the case of social workers, school nurses and health visitors, a high percentage indicated they would attend compared to only 14% of GPs. In the post-Laming stage there was an increase in GPs indicating they would attend, but this was still only 24%. The low percentage of GPs who indicated they would attend reflects the findings of other research studies (Tompsett et al 2009) and some of the possible reasons for this are discussed in chapter 5. Beyond the child protection conference stage, social workers played the dominant role and there was evidence of poor engagement of other professionals in terms of a multi-agency approach to developing plans. This is concerning, given the fact that an interagency protection plan is a prerequisite in government statutory guidance (HM Government 2010).

To date, there have been missed opportunities at both the level of national contracts and local commissioning arrangements to develop robust contractual arrangements to ensure health professionals fulfil their safeguarding duties in full. It is important that, with the ongoing changing landscape of commissioning, arrangements are developed through contract monitoring which have the ability to reassure commissioners to the robustness of safeguarding arrangements within the services they commission. The ongoing changes within health and the imminent changes, which will see commissioning responsibilities transferring from Primary Care Trusts to GPs, are unlikely to ensure fuller engagement of GPs in the full range of safeguarding practice.

9.4 Roles and responsibilities in safeguarding children and the division of labour

Stanley (2005) argued that professional and occupational hierarchies can operate within child welfare settings, with certain professionals afforded more voice, power and influence over others. Within the current research study, the understanding of the individual's own role in safeguarding children and their understanding of the role of other professionals was explored. Within the research there were clear differences in terms of how professionals perceived their own role and responsibilities and those of other professional groups. The difference in perceptions featured in cases of both children in need of services and children in need of protection. The majority of GPs did not see themselves as having a role with children in need, and their perception was that in the case of child protection after registration, their input was minimal. As would be expected, there was recognition across the professional groups of the importance of the social worker to the child protection process and there was also a high percentage of respondents who recognised the importance of the role of the health visitor. However, the role of other health professionals and professionals outside of health and social care were not consistently recognised as key to the safeguarding continuum. The reason for this is not clear, but may reflect the poor understanding of the roles of these professionals. The findings in this research reflect that of Hornby (1993), who found a lack of understanding of the roles and responsibilities of others. Findings from the current research raise the issue that there appears to be a lack of improvement in the understanding of the role of other professionals, working within safeguarding, in a period of almost 20 years. The understanding of roles and responsibilities is a key requirement if effective collaboration is to be achieved. In chapter 5, the work of Reder and Duncan (1993) was discussed and they identify role confusion as one causal factor in communication breakdown.

With a history of national documents outlining the responsibility of a range of professionals (HM Government 2006a, HM government 2010), multi-agency child protection procedures being in place and a range of multi-agency child protection training being delivered, the fact that there is still a lack of understanding of roles and responsibilities raises concerns.

9.5 Joint assessment and the assessment of risk

There is no question that assessment in the field of safeguarding children is challenging and complex. The phenomenon of child abuse is, in itself, socially constructed, without fixed or permanent boundaries, making precise definition impossible. Within safeguarding, decision making is based on an assessment and from that assessment a decision is framed by a professional's knowledge and by professional and organisational guidance. Part of the assessment process includes the assessment of risk. The current research project considered the multi-agency process of assessment, including risk assessment. The strategic drive in safeguarding as a response to high profile cases such as Peter Connolly, which focuses on policy change and scrutiny, is likely to promote risk aversion, which may lead to assessments being too narrow in focus.

Respondents in the current research, identified the pressure and stress that work in this area poses and some of the factors identified as contributing to the stress, were the result of changes in response to high profile cases. As public inquiries and serious case reviews into the deaths and serious injury of children through abuse regularly highlight, it is not only important to undertake an assessment that is crucial to professional practice, but also to share the assessment and subsequent decisions with relevant others.

Within the current research, responses demonstrated no clear pattern of differentiation between social worker and health professional assessment in either the pre or post-Laming surveys. School nurses in both the pre- and post-Laming surveys were more likely to assess scenarios involving pre-school children as more serious in comparison to the other professionals. This may be due to a lack of exposure to pre-school children in practice.

In ensuring that assessments and risk assessment are robust, supervision and management oversight are important. Within the current research, there was evidence of professional case consultation for social workers, health visitors and school nursing but for most GP respondents, this was not evident. This may relate

to the lack of a safeguarding supervision system being established for GPs or their lack of understanding of the roles of named and designated health professionals.

9.6 Understanding of thresholds

The findings from the current research project raise questions about the nature of risk assessment and the application of thresholds of intervention. The findings from the research indicate the different application of thresholds between both professional disciplines and between the two boroughs, both for children in need of services and children in need of protection. Although it could be suggested that this may, in part be related to experience and thus confidence of professionals within an area of practice (Francis 2006), this was not the case in the current research. The age range of professionals, the length of time spent in their current roles and their exposure to both child in need and child protection practice were similar across the two boroughs as discussed in chapter 8. The differences in policy and practice for children in need, between the two boroughs may be a possible explanation for differences in the application of thresholds. Within safeguarding, it is important that there is a clear multi-agency understanding of thresholds (Axford and Berry 2005). This is discussed in chapter 4. In more recent times, a number of safeguarding children boards have published documents setting out multi-agency thresholds; however, at the time the research was undertaken this was not common practice. Differences in thresholds used by different professional groups leads to difficulties in conceptualising, and therefore recognising abuse.

9.7 Emotional impact of child protection work

In undertaking the current research project, there was a clear finding that for a number of professionals, the emotional impact of safeguarding children work was an issue. The issue of stress in safeguarding children work has been highlighted by a number of researchers, over a number of years (Wallen 1977, Skaff 1988, Laming 2009). Stress experienced by professionals is likely to impact on their work life and on their ability to work collaboratively. Despite organisational objectives to manage risk and minimise uncertainty, professionals working in the field of safeguarding children have to tolerate a level of uncertainty, which in turn often manifests as professional stress. Despite the fact that the issue of stress for practitioners working in areas of safeguarding children

practice has been identified for a period of over 30 years, a number of staff in the current research reported feeling insufficiently supported. Professional support is an important requirement if successful collaboration is to be achieved, and indeed if children are to be adequately safeguarded. This was highlighted by Laming (2009) who identified the need for managers to recognise that anxiety in practitioners undermines practice. In the current research, literature reviewed, and discussed in earlier chapters, highlights the effect of policy change, and in particular the pressure this places on professionals, already practising in a stressful field. Interestingly, although Laming (2009) identifies the need for managers to recognise anxiety in the field of safeguarding, practitioners in the current research identified, reports such as Laming's, as a cause of stress. These findings reflect those of Holmes (2010), discussed in chapter 5. The recent research clearly demonstrated the impact of working in an isolated and stressful area of practice, such as child protection, and clearly identified how policy change can add to such stress.

9.8 The impact of policy change

Throughout the period the research was taking place, there was continuous development in terms of policy publication and implementation and this was influenced in part by the publication of the Laming Inquiry. The research considered the impact of the Laming Inquiry on safeguarding practice within the two boroughs. As would be expected, the majority of respondents believed the Laming Inquiry had impacted on collaboration in both areas of practice, children in need of services and children in need of protection. The number that felt it had impacted on practice where children are in need of protection were marginally higher compared to children in need of services.

In the current research, the areas that the greatest number of respondents identified as improving as a result of the Laming Inquiry were improved joint working, including joint visits between health and social care practitioners and joint audits, improved information sharing and understanding of thresholds. Respondents also identified improvements in multi agency procedures and improved multi agency training. In addition to the changes that were seen as positive a number of concerns were raised that were viewed as negative consequences as a result of the Laming

Inquiry. The main concerns identified included, lack of increased funding to meet increased demands and the need to develop preventative work alongside protection, with increased training attendance requirements but no increase in funding or staff. A number of respondents identified the pressures of increased scrutiny. This could of course also be viewed as a positive in terms of assuring professionals that safeguarding services are robust, although the experience from Haringey suggests that approaches to scrutiny have not always obtained an accurate assessment or there has been a failure to recognise that assessments need to be reviewed regularly as safeguarding practice needs to respond constantly to new challenges (Munro 2011).

Chapter 2 considered what happens at the point that policy is translated into practice and it is clear that in the end, policy implementation comes down to the people who actually implement it (e.g health professionals and social workers). They exercise a large amount of influence over how public policy is actually carried out. The literature reviewed identify a number of pressures that influence the way in which policy is implemented, including the problem of limited resources, a finding from the current research project. The current research illustrated how, well intentioned policy change, can have an adverse effect in an area that is working well. The policy change can in fact reduce service provision.

9.9 Resources for safeguarding children

Findings from the current study highlighted resource constraints as a barrier to achieving effective collaboration in safeguarding children within the two boroughs. This was particularly expressed in relation to the implications of insufficient resource allocation to meet the increased demands in safeguarding practice as a result of Laming (2003). Research undertaken by a number of authors has identified the consequences of the inadequate resourcing of safeguarding (Lipsky 1980, Aldgate 2002). The current research identified a number of negative impacts on safeguarding practice due to the increased demands of major changes such as the Laming report and these included the increase in paper work and perceived bureaucracy, which affects the amount of time available for client contact. The current research did not explore the strategies that practitioners adopt in order to cope with budgetary pressures, however the literature reviewed and

discussed in chapter 2 provides some evidence from other researchers work. Outcomes of inadequate resourcing frequently results in the raising of thresholds or the professional failure to undertake a full assessment because they know they will not have the resources to address the findings. In the current research respondents made reference to resources affecting their ability to develop services for children in need. With ongoing resource constraints, it is important that cost effective approaches are developed, and evidence from the literature reviewed and the experience of respondents working in borough 2, suggests multi-agency approaches can achieve this. A respondent failing to undertake an assessment when faced with limited resources raises the issue of the need for professionals across the agencies to understand that undertaking an assessment does not equate with a promise of services. It is important that professionals understand that if they fail to identify unmet need, it results in a situation where there is no opportunity to influence and shape policy and service delivery. If unmet need is not evidenced it will not be part of processes of gathering of data and information to plan future service priorities.

Parton et al (1997) state, that the good intentions of practitioners, researchers and policy makers alike, have been undermined by chronic under resourcing. As services struggle to resource need there is a shift in threshold application, with the resultant increase in risk and the knock on effect of professional stress and potentially burnout as was evident in the current research.

9.10 Factors that enhance or inhibit collaboration

It is widely accepted that inter-agency collaboration and information exchange are core issues in ensuring effective safeguarding practice as discussed in chapter 3. The need to develop these aspects of practice has been identified as a key issue in research as well as being promoted through policy and legislation. Complex social issues such as child protection cannot be solved by single agencies or professions and the findings of the current study suggest that the principle of joint working, both at ground-level and in strategic terms, is generally accepted.

Not surprisingly, findings in the current research identify that the nature and quality of joint working arrangements varies considerably between different

agencies and professionals. However, responses suggest that there were a number of factors that improved collaborative working, including shared thresholds and the practice of informal joint meetings. At a time where organisational and team changes across a number of agencies are a constant feature the opportunities for such practices should not be lost.

Information sharing between professionals and agencies has been identified as a key factor relating to the nature and quality of child protection work in recent inquiries (O'Brien, 2003, Scottish Executive 2005a). This aspect was identified as important by respondents and comments suggest that health and social care professionals regard information sharing as an important aspect of child protection work. General frustration was expressed by participants in the current research, about the consistency of practice in this area, with variability between different agencies. Many of the barriers to effective inter-agency working and information sharing appear to be rooted in low levels of trust and confidence in how different professionals and agencies engage in child protection work. The findings here suggest that the picture is very variable in practice. While there are some indications that trust is developed through improved systems, structures, policies and procedures, for many, effective collaboration is based upon the quality of individual working relationships that workers build between themselves.

9.11 Limitations of the research

In undertaking the current research there are a number of limitations which are acknowledged by the researcher. The current study was undertaken in two London boroughs with a small sample size, therefore there may be limits to the extent to which the findings can be generalised to the wider practice of safeguarding. It also needs to be acknowledged that the research has taken place over a number of years, resulting in the early data being somewhat dated. The period of time in which the research has taken place has been one of increased scrutiny and constant changes within safeguarding at national and local levels, therefore some of the findings from the research may no longer be reflective of current safeguarding practice.

Throughout the time the research has been undertaken, the researcher has practised in a specialist safeguarding role, and at the time the research commenced in one of the organisations included in the study. It is therefore possible that the researcher could have introduced her own biases. Action taken to minimise this are discussed in chapter 7.

The use of vignettes in the study has a number of advantages as discussed in chapter 7; however it is important to be mindful of the indeterminate relationship between beliefs and actions. The meaning people ascribe to certain contexts may not be born out in their subsequent actions.

The researcher acknowledges that the research is solely based on the perceptions of professionals with a lack of attention to the voice of children and young people as service users. The inclusion of the perceptions of children and young people would have greatly enriched the study.

9.12 Concluding reflections

Collaborative working within the field of safeguarding has been high on both national and local agendas and reflected in government policy. The current research found areas of good practice and changes in practice following the publication of the Laming Inquiry. However, in acknowledging that the current situation leaves much scope for improvement in collaborative working arrangements between health and social care professionals, a number of respondents provided suggestions about the way forward. Reflecting comments elsewhere in this report, the issues of further developing joint training and raising awareness of other professionals' roles and responsibilities were high on the agenda. A number of obstacles will have to be overcome in order to generate more effective inter-agency practice, including the development of systems to support professionals in this area of work that is experienced as stressful. However responses obtained through the administration of the questionnaire indicate that many social care and health practitioners already have a good understanding of what needs to be done and respondents provided a number of suggestions of ways to overcome these barriers. Some of these suggestions concerned more formal

measures including the need for coterminous boundaries, shared procedures, improved joint training and shared thresholds, other suggestions are ones that could be taken forward in practice including jointly funded posts and collocation. A number of practitioners identified the issue of stress within this area of practice and the implementation of a system of multi-agency supervision would provide a system of support and yet have the other potential advantages of enhancing understanding of different professional roles and responsibilities and promoting joint assessments and common understanding of thresholds.

The findings of the research demonstrated a marked difference in the multi-agency response to children in need, in comparison to children in need of protection. It was evident in the current study that the area that adopted multi-agency policies and practice for children in need, identified greater levels of satisfaction with collaborative approaches and reported successful implementation of team work. There is some evidence from the literature reviewed that such approaches result in improved outcomes for children. There needs to be a clear practice objective and project goal to develop multi-agency systems and processes for children in need.

9.13 Recommendations

In undertaking this current research and reflecting upon the learning that has taken place, as a result of the valuable input from professionals who participated, and acknowledging limitations of the study, the following recommendations are made:

Recommendations at the level of practice

1. Health and social care organisations should consider the development of multi-agency practice teams to provide services for children in need.

2. Health and social care organisations should consider the development of multi-agency safeguarding supervision, based on a model that allows reflection, particularly for complex cases and includes the supportive element for practitioners.

Recommendations at the level of policy

3. Health and social care organisations should undertake assessments at the time of policy change to identify the financial and human requirements to resource the change.

Recommendations for future research

4. Further research is undertaken to explore in greater depth the emotional impact of safeguarding work and potential approaches to support professionals.

5. Future research is undertaken to explore the child and young persons experience of collaborative approaches in safeguarding practice.

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APPENDICES

Appendix I

Children in need of services are defined by the Children Act section 17 as
he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by a local authority under this part;
his health or development is likely to be significantly impaired or further impaired without the provision for him of such services or he is disabled. (Department of Health 1989).

Children in need of protection are described in section 47(1) of the Children Act 1989. Section 47 of the Act places a duty on local authorities to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering or is likely to suffer Significant Harm. A Court may only make a Care Order or Supervision Order in respect of a child if it is satisfied that:

The child is suffering, or is likely to suffer Significant Harm; and that the harm or likelihood of harm is attributable to a lack of adequate parental care or control (section 31).

Under Section 31(9) of the Children Act 1989, as amended by the Adoption and Children Act 2002:

- 'Harm' means ill-treatment or the impairment of health or development, including for example impairment suffered from seeing or hearing the ill-treatment of another;
- 'Development' means physical, intellectual, emotional, social or behavioural development;
- 'Health' means physical or mental health; and
- 'Ill-treatment' includes sexual abuse and forms of ill-treatment that are not physical.

Section 53 of the Children Act 2004 amended section 17 and section 47 of the Children Act 1989,

- so that before determining what, if any, services to provide to a child in need under section 17, or action to take with respect to a child under section 47, the wishes and feelings of the child should be ascertained as far as is reasonable and given due consideration.

Appendix 2

Abuse and Neglect

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Appendix 3

COLLABORATIVE WORKING IN CHILD PROTECTION

Professional Code _____

Identity No. _____

Thank you for taking the time to complete the questionnaire

SECTION 1

In completing the following form please tick the relevant box for fixed choice questions and for open ended questions, please answer in the light of your normal practice, perceptions or experience.

1. Age
   - 20-24 ☐
   - 25-29 ☐
   - 30-34 ☐
   - 35-39 ☐
   - 40-44 ☐
   - 45-49 ☐
   - 50-54 ☐
   - 55 + ☐

2. Sex m ☐ f ☐

3. Do you have personal experience of bringing up children?

   Yes ☐ No ☐

4. Ethnic group (*please describe your ethnic origins*)

   - Bangladeshi ☐
   - Black African ☐
   - Black Caribbean ☐
   - Black Other ☐
   - Indian ☐
   - Pakistani ☐
   - White ☐
   - Chinese ☐
   - Other Asian ☐
   - Other ☐
   - (*Please describe*) ☐

5. What is your job title? Please indicate occupation and grade (*if applicable*)

Social Worker ☐
Senior Social Worker ☐
General Practitioner ☐
Health Visitor ☐
School Nurse ☐
Other ☐
(*please specify*)

6. Please list your occupational qualifications with dates.

7. What year did you start work in your current profession?

8. What year did you start work in your current post?

9. In the last month please estimate as a % how much of your working time you spent on children in need matters.

0% ☐
1 – 25 % ☐
26 – 50 % ☐
51 – 75 % ☐
Above 75 % ☐

9.1. Was this time expenditure typical?

Yes ☐ No ☐

If not, is it usually:

Greater ☐
Less ☐

9.2. In the last month please estimate as a % how much of your working time you spent on child protection matters.

0%	☐
1 – 25 %	☐
26 – 50 %	☐
51 – 75 %	☐
Above 75 %	☐

9.3. Was this time expenditure typical?

Yes ☐ No ☐

If not, is it usually

Greater	☐
Less	☐

SECTION 2

The following sections present a series of brief vignettes that are based on "real life" cases. Each vignette describes a case that may be classified as a child in need of services or a child in need of protection as a result of physical injury, sexual abuse, emotional abuse or neglect.

Please rate the incident on a scale of increasing seriousness in relation to the welfare of the child from 1 to 5 where 1 is that you believe the incident is very serious and 5 that the incident not serious at all. Please make the judgement independently for each case.

Although limited information is provided, please base your decision on your professional experience of working with families with children.

10. A 3 year old child from a two parent family who have recently arrived in England seeking political asylum, found wandering across a main road two streets from home.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.1. A 4 year old child from a two parent white British family whose father frequently shows the child and the child's friends pornographic videos.
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.2. An 8 month old white British child living with two parents. Both parents have learning disabilities. The child's weight gain has continued to be slow and at 8 months is below the 0.4th centile. At birth, weight was above the 25th centile.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.3. A 7 year old white British child living with her mother. On one occasion the police visit the house having received a call from the child describing her mother as being drunk. On arrival at the house the child is at home with her mother and the mother is found to be in a "drunken state". No food is found in the home.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.4. A 9 year old white British child living with two parents. The child frequently witnesses domestic violence and on several occasions has witnessed his father being arrested following such incidents. The child has recently been excluded due to his aggressive behaviour to other school children.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.5. A 6 year old Nigerian child lives within a one parent family. At a recent access visit to the child's father a hand mark is noted on the child's shoulder. The child reports this was as a result of being hit by the mother for being late home from school.

1☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.6. A 16 year old Asian girl living with both parents who reports her father has had sexual intercourse with her regularly for several years.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.7. A 6 year old Nigerian child living with its mother who has had a long history of suffering with mental health problems. There are no toys apparent in the home and the mother provides no stimulation for the child. School attendance is poor.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.8. A 4 year old Asian child whose parents constantly criticise stating they wish the child had never been born and constantly compare the child to the younger siblings.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10.9. A 10 week old white British baby living with both parents is admitted to hospital and is diagnosed as having had a cerebral hemorrhage that is consistent with severe and sustained shaking.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

11. Please identify the factors that you considered when assessing the seriousness of the above vignettes.

SECTION 3

The following vignette is the type of scenario you might come across in the course of your professional work. Please answer the questions that follow in the light of your experience and professional practice.

In the course of your work you hear from a client that a 3 month old baby living next to her is constantly crying, that the house is very dirty and that at a recent visit she observed the baby's nappy being changed and had noticed severe nappy rash. The mother is 24 years old, the father 28 years old. Both are unemployed and in receipt of benefits. They also have a 6 year old child.

12. Would you take any action?

Yes ☐ No ☐ Don't know ☐

If yes go on to question 12.2
If no go on to question 12.3

12.2 If yes what would you do now?

12.3 If you chose to take no action what was your reason?

12.4. Would you discuss the case with another professional before deciding on a course of action?

Yes ☐ No ☐ Don't know ☐

12.5. If yes who would you discuss the case with?

12.6. Would you attempt to find out whether the child was subject to a child protection plan?

Yes ☐ No ☐ Don't know ☐

12.7. If no please give reasons.

12.8. Do you think a child protection conference should be called at this stage?

Yes ☐ No ☐ Don't know ☐

12.9. Please give the reasoning for your decision.

12.10. If a child protection conference were convened would you attend?

Yes ☐ No ☐ Don't know ☐

12.11. Please give the reasons for your response.

At this stage there may be a range of activities with different professionals in relation to the case.

13. Which of the following activities would you expect to be involved in such a case?

Receiving information from professionals ☐
Sharing information with professionals ☐
Joint planning ☐
Giving expert opinion ☐
Jointly discussing early perceptions/knowledge ☐
Maintaining liaison/updating information ☐
Jointly plan separate interventions ☐
Joint action ☐
Other ☐
(*please specify*)

Further information reveals that the mother has mild learning disabilities and is suffering with postnatal depression. The baby's weight is on the 0.4th centile. The 6 year old has poor school attendance and is reported as being aggressive to other children when in school. The baby has a small bruise on the right cheek.

14. Would you take any action?

Yes ☐ No ☐ Don't know ☐

If yes go on to question 14.1
If no go on to question 14.2

14.1. If yes what would you do now?

14.2. If you chose to take no action what were your reasons?

14.3 Would you discuss the case with other professionals before deciding on a course of action?

Yes ☐ No ☐ Don't know ☐

14.4 If yes who would you discuss the case with?

14.5. Would you attempt to find out whether the child was subject to a child protection plan?

Yes ☐ No ☐ Don't know ☐

14.6. If no please give reasons.

Following a strategy discussion, it is decided that a child protection conference should be held. At the conference it emerges that the couple have considerable debts, including rent arrears and are possibly facing eviction. The mother who is depressed is not caring for the family and is finding it difficult to meet the needs of the children. There is evidence of little food in the home.

The father cannot understand his wife's behaviour and is frequently verbally aggressive towards her in the presence of the children. The baby's weight gain continues to be poor and the six year olds aggressive behaviour is worsening. The six year olds academic progress is reported as being below the expected standard. The school staff think there may be a problem with hearing and in the past the family have failed to attend two hearing tests for the child.

15. Bearing in mind the information given in the vignette, please list the professionals you would expect to attend the child protection conference.

16. Which of the following decisions do you think should be made from the case conference?

For the 3 month old child

Become subject to a child protection plan ☐ Non registration ☐

Child in need ☐

For the 6 year old child

Become subject to a child protection plan ☐ Non registration ☐

Child in need ☐

17. From the list indicate individuals that should contribute to the child protection plan.

	Yes	**No**	**Don't know**
Social Workers			
Health Visitor			
Teachers			
School Nurse			
GP			
Paediatrician			
Psychiatrist			
Psychologist			
Community Psychiatric Nurse			
Community Learning Disability Team			
Accident and Emergency			
Education Welfare Officer			
Police			
Family members			
Others (please specify)			

SECTION 4

18. Please comment on the extent to which a multi-agency approach is adopted in your work setting, when working with families where there are:

    a) Children in need of services

    b) Children in need of protection

19. In your experience has the findings of the inquiry into the death of Victoria Climbie resulted in changes in the way health and social care staff work together locally with:

    a) Children in need Yes ☐ No ☐

    b) Children in need of protection Yes ☐ No ☐

If you answered Yes to either 19a or 19b please answer question 20 and 21. If you answered No please answer question 21.

20. Please indicate in what way working between health and social care professionals has changed locally as a result of the Laming Inquiry with

    a) Children in need

b) Children in need of protection

21. What do you believe promotes effective collaborative working between health and social care professionals in work to safeguard children?

Please return the completed questionnaire by 15th January 2008 in the enclosed envelope to:

Amanda Boodhoo,
Consultant Nurse for Safeguarding Children
Surrey PCT
120 Victoria road
Horley
Surrey RH6 7AB