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Working in the field of safeguarding children requires well-developed skills of communication and intervention. Sue Smith considers how the individual, organisational and cultural emphasis upon certainty may affect the professional use of information and knowledge in assessing vulnerable families and children

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Contemporary discourses focusing on safeguarding children within the NHS highlight the deep-rooted challenges in separating assessment and decision-making from management of risk and minimising uncertainty. However, at an arguably simplistic level, it is true to say that a clinical decision is based on an assessment and that a decision is framed by a professional's knowledge and by professional and organisational guidance.

As public enquiries 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.

The latest Care Quality Commission (CQC) review into safeguarding children considers the involvement and action taken by health bodies in relation to the tragic case of Baby Peter.[1] The review repeatedly highlights concerns about systems and processes relating to communication, sharing information and knowledge and multidisciplinary awareness of professional assessments across departmental and organisational boundaries.

Before consideration of the use of knowledge and information in decision-making, it is worth revisiting the principles of good assessment in relation to children. Strange as it might seem, anecdotal evidence suggests that there is confusion about whether assessment is a framework, an artefact or a process!

Principles of assessment

A basic principle of good assessment is an understanding of child development as a core area of knowledge for all professionals, practitioners and managers alike.[2] This must be located within the wider context of national, local and organisational policy.

The ecological framework of assessment ensures that it is also located within the context of the child's environment, including consideration of internal and external, social and cultural influences. The *Framework of Assessment for Children in Need and Their Families* provides the basis for an ecological assessment incorporating parenting capacity, family and environmental factors and the child's developmental needs.[3,4]

Seden emphasises how the framework provides a "systems" approach to assessment where areas of strength are considered alongside areas of need, prompting professionals to think holistically and analytically before intervention.[3] A simple but often forgotten focus of the *Framework of Assessment* is that assessment is not a one event, nor is it an end in itself; rather it is a process that is subject to ongoing review and as such informs the direction and focus of an intervention.[4] The Framework supports the gathering of data and information, the analysing of that information, the decision-making which follows, the planning of the intervention and the review/evaluation of the intervention.[3]

In practice, professionals may stop at gathering the data and information and as the biennial analyses of Serious Case Reviews also highlight, professionals may

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not consider the data gathered by other colleagues across organisational and professional boundaries.[5,6]

Complexity of assessment

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. The complex interaction between the multifaceted layers of strengths and needs that may feature within a family, and that may be influenced to different degrees by environmental factors, will vary with each case. Precise prediction is, therefore, an unrealistic goal. Despite organisational objectives to manage risk and minimise uncertainty, professionals working in the field of safeguarding children have to tolerate a level of uncertainty.[7] Even technological and algorithmic protocols designed to minimise uncertainty are shown to be unhelpful when dealing with value sensitive problems.[8-10]

Parton et al highlight how the process of social negation between different values and beliefs, social norms, professional knowledge and perspectives about parenting, child development and children that are inherent in child protection work, have at its centre moral reasoning and moral judgements.[11] This is echoed by Taylor and White, who describe the nature of child health and welfare as being uncertain, requiring the need for qualitative and complex judgements to be made.[10] However, nurses will often do their best to deny that any part of their work is subject to value judgements or any degree of subjectivity. In reality, professionals will combine formal guidance and procedural knowledge with their own tacit knowledge and past experience, and will not make decisions based solely on what they see before them.

Even in the highly scripted and technology controlled environment of NHS Direct, nurses will combine their professional knowledge with that of the algorithmic protocols and experience the same feelings as all decision-makers in relation to confidence, certainty and uncertainty.[8,12,13] NHS Direct studies have highlighted nurses' reluctance to ask questions about how a parent is coping with a persistently crying baby, despite being prompted by the computer algorithm.[8]

Colleagues have openly admitted that they do not always undertake a full assessment and "lift up the stone" to see what's underneath because they know they will not have the resources to tackle what might be lurking there. This raises the question, does undertaking an assessment equate with a promise of services? If we do not identify unmet need, how can we ever hope to influence and shape policy and service delivery? Is this not part of gathering of data and information?

A more likely explanation for professionals' reluctance to look deeper lies in the uncomfortable nature of dealing with uncertainty. Lazenbatt and Freeman offer some suggestions for nurses' reluctance to ask value sensitive questions that may yield more uncertainty than they solve and highlight how uncertainty of process and anxiety and fear of "being wrong" are key factors.[14] Their findings also " ... illustrate a substantial gap between their ability to recognise maltreatment and knowledge of the pathways for reporting it".

Information and knowledge

Framing the discourse about assessment and decision-making is the apparent growing tension within the NHS about what is more important – information or knowledge. The debate regarding the value of different styles of bureaucracy and the type of knowledge it utilises is raised by Lam and described by Ruston.[15,16] Lam contests that the dominant knowledge type depends on the type of organisation. She identifies an alliance between "embrained knowledge" and "professional bureaucracy" typified as being individual and dependant on skill, where highly skilled professionals acquire knowledge through formal education and training and are governed by professional bodies.

This description could be applied to a variety of professions including medicine and nursing. Lam

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goes onto identify "encoded knowledge" typified as knowledge which is codified, explicit and collective, which facilitates organisational control and does not capture individual skill, judgement or tacit knowledge.[15] Encoded knowledge is closely aligned with a machine bureaucracy, features of which are described by Flynn as " ... a clear division of labour and specialisation, close supervision, and continuous efforts to codify knowledge and skills to reduce uncertainty (and variation), and an emphasis on managerially generated rules, monitoring procedures and performance standards. A machine bureaucracy tries to minimise the use of tacit knowledge, and corrects mistakes through performance monitoring".[17]

The ever-increasing numbers of performance indicators and appraisal systems lends some support to the notion that the dominant knowledge type within the NHS is being increasingly shaped by encoded knowledge and a machine bureaucracy represented by the scheme of clinical governance.[16,17] Parton provides a context of New Labour's modernisation agenda citing Newman and highlighting how practice that is based on evidence requires measurement and audit in order to contribute to the "new form of managerialism".[18,19]

Aas draws on the view of Brown and Duguid, describing information as collective and as the processing and storing of knowledge that can be picked up, possessed, passed around, put in a database, lost, found and compared.[20,21] In contrast, knowledge is

personal, hard to pick up, hard to transfer and not easy to quantify.[21] The authors clearly connect knowledge to practice as it includes and makes sense of information but also embodies tacit dimensions drawn from practical experience. They warn that a shift from knowledge to information represents a shift from people to a disembodied process. The discourse resounds with the

> **"The process of assessment in any medically focused healthcare setting can arguably be seen as a long-tried and tested means of hypothetico-deduction"**

description by Manovich of narrative and database as "enemy ontologies".[22] Narrative is described as stories that have a beginning and an end, are presented by an author who decides the order it will be heard and which creates a logic. Database is described as information that is collected and compressed, the order is defined by the person using it and logic is selected. Evidence of which "ontology" is growing in the field of safeguarding children can be found in the Common Assessment Framework (CAF). As Peckover et al found, CAF forces the author to present information within a certain structure and format.[23] This format is found to disrupt narrative, lack chronology and is difficult for the reader to interpret and understand.[23]

The authors highlight how these issues and substantial differences in policy implementation, raise "serious questions" about the use and development of CAF and other "technological solutions" as a means of addressing well documented concerns about effective information sharing in the safeguarding children and child welfare arena.

Nurse identity and clinical judgement

The debate regarding the privileging of certain forms of knowledge has some resonance with the issue of nursing identity. Kelly and Symond trace the history of nursing through discourses on caring and emphasise how the care services privileged cure associated with medicine over care associated with nursing; with the power clearly assigned to the former.[24] They go on to state how " …. 'powerful' interpretations of governmentality tended to devalue nursing care in favour of developing technological interventions which were the province of the medical profession … generations of nurses have therefore been subject to the need for acquiescence to medical dominance and an expectation that they would care for groups labelled by society as unresponsive to regimes of cure … ".[24]

The authors describe the "identity crises" that has ensued as nurses have sought "professional prestige" by privileging the medical profession's use of science over their own caring skills and the contribution of these skills to providing a cure.[24]

The process of assessment in any medically focused healthcare setting can arguably be seen as a long-tried and tested means of hypothetico-deduction, the aim of which is to try to reduce risk. This approach may serve professionals well in some areas of healthcare, but it has been criticised as a blanket means of dealing with ambiguity and uncertainty involved in everyday decision-making in relation to safeguarding children.[9] This is supported by Hanlon et al who reflect on the role of management of NHS Direct as delivering "certitude" and see this, coupled with the need to meet organisational targets, in conflict with the rationality of nurses who see the essential elements of delivering a good quality service as being anchored to maintaining flexibility, autonomy and discretion.[25] They state:

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"There is a real danger that professionals may still choose to avoid the uncertainties that a deeper assessment may reveal; a robust, supportive supervision framework may help to mitigate against this"

"In many ways, what is occurring in NHS Direct is a struggle over what form of knowledge predominates in the organisation".[25]

Conclusion

The nature of the work of safeguarding children is complex, multifaceted and uncertain. It cannot be distilled to risk assessment checklists or to algorithmic protocols. Tools and frameworks, guidelines and algorithmic protocols must support clinical experience and tacit knowledge, not define them. There is a real danger that professionals may still choose to avoid the uncertainties that a deeper assessment may reveal; a robust, supportive supervision framework may help to mitigate against this.

The biennial analysis of serious case reviews supports Lord Laming's comments from 2003 that the key challenge for professionals is less about how well we identify vulnerability, or about the procedures in place to deal with issues we have identified, but about enacting procedures once we have identified levels of concern and vulnerability.

How we combine our unique nursing skills of assessment with clinical expertise, sharing and integrating information and knowledge will have a direct impact on our decision-making and, ultimately, outcomes for children and families. ●

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