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Facilitated Practice-based Research (© University of Sunderland) Report

Working together in Safeguarding Children and Vulnerable Adults

Practice Research Project Team consisting of social work practitioners, educators and researchers (in alphabetical order):
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EXECUTIVE SUMMARY: The purpose of the report is to share findings from a small-scale exploratory research study, conducted by a group of practitioners who participated in a Facilitated Practice-based Research project. The aim of the research was to understand how partner professionals, e.g. from health, mental health, education, police, housing, charities etc., perceive and experience safeguarding when working with social workers. A qualitative survey was distributed across the North-East region with all partner professionals invited to participate, who had experience of working with any Local Authority in the NESWA partnership. Each survey consisted of five open-ended questions giving participants the opportunity to explain their responses, and a total of 67 responses were received – of these 33 participants worked with adults and 34 with children.

Conclusions: There was consensus among all partner professionals, regardless of whether they worked with adult or children's social workers, that transactional communication was significant, i.e. not just one-way, but information and tasks shared back and forth; and that partner professionals often felt undervalued and not respected by social workers. When referring to profession-specific risk, adult partner professionals highlighted issues such as care home residents with pressure sores, carers not bringing service users to appointments, or a resident with a learning disability spending a lot of money on a relative. Children's partner professionals highlighted issues such as absences from school, unexplained observable injuries/marks/bruises, or unexplained weight loss. Where there was difference, this related to two key areas. For adult partner professionals they referred to systemic issues that were perceived as impacting on safeguarding, e.g. a lack of funding and resources in adult social care which, it was felt, could be better dealt with by bringing health, social care and social work together into a holistic service. For children's partner professionals, a consistent approach was highlighted as important, shown in their concerns about high staff turnover, disparities in advice and processes as well as not enough time given to read reports.

Report recommendations:

- NESWA to develop training to help both social workers and partner professionals understand what profession-specific risk looks like and to embed professional respect of partner professionals across **all** partners.
- Local Authorities to re-evaluate their policies and practice to ensure they are clear and consistent in applying thresholds for safeguarding intervention.
- Local Authorities to develop approaches in giving specific feedback to partner professionals on referrals, especially those not taken up.

Recommendations for further research

- To explore the differences in perceptions regarding what working together means for Housing departments; and at what point those in Education and Health feel their safeguarding duty is discharged.

Introduction: The research topic, which is the subject of this report, emerged through a group of practitioners engaging in a Facilitated Practice-based Research (FPR) (©University of Sunderland) programme with academic educators and researchers from the University of Sunderland (Deacon, 2023). The aim of FPR is to support practitioners to reframe their practice skills as research skills, in order to complete their own practice-based research. During the programme, the cohort worked together to co-construct, design, implement and analyse a piece of group practice research relevant to the organisation which, in this case, was the North-East Social Work Alliance (NESWA). NESWA are a charitable body that oversee the social work teaching partnership in the North-East of England, which includes all Local Authorities (LAs) and Higher Education Institutions (HEIs) (see Appendix 1 for list of members).

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Research aim: Two research topics emerged through group discussions about current areas of concern for the practitioners in the cohort. The topic that is the basis of this report is an exploratory study to understand how partner professionals working with both children's and adult services perceive and experience safeguarding practice when working with social workers across NESWA Local Authorities.

Research question: How do partner professionals perceive and experience safeguarding of children and adults?

1. How well do partner professionals feel they understand their own duties concerning safeguarding?
2. How do partner professionals identify safeguarding risks and what do they look like in practice?
3. What do partner professionals expect social work practitioners to do regarding safeguarding, and what is their experiences of them in practice?
4. What has been helpful/supportive when engaging with social work practitioners in safeguarding?

Participants: Partner professionals currently involved in safeguarding children or safeguarding adults procedures, excluding social workers, e.g. education, health, mental health, police, probation, third sector organisations, private sector organisations, housing etc. Restricted to those who have had interactions with the Local Authority organisations in NESWA (Appendix 1).

Context of the research study: The significant thing in this research study is the concept of intention versus effect. Whilst social workers may intend to do something, this does not automatically mean it is received in that way. Emancipatory Practice Development encourages evaluation of services to take an inverted triangle (bottom-up) approach and look at how services are received, regardless of intention. This means in this study difficult questions have been asked to understand how social work safeguarding practice is received by partner professionals with the intention of informing good practice around working together (Deacon, 2022).

Literature review: Previous research highlights that different professions have different cultural perspectives regarding risk, and that in order to work together it is important for social work practitioners (as safeguarding leads) to understand this.

Profession-specific risk: According to Peckover and Golding (2017) different understandings and priorities shape interprofessional practice in relation to safeguarding, and these professional knowledge frameworks can create issues in effective multiagency working. For example, when considering domestic abuse: in child protection the onus is placed on mothers to protect children and

domestically violent males are constructed in terms of their impact on parenting in the family; whilst in the criminal justice arena domestically violent males are constructed as perpetrators and professional responses are framed in terms of their offending behaviour and risk. Further to this, Ratcliffe et al. (2020) highlighted that when topics/practice becomes more complex, partner professionals can become anxious and uncertain about how to understand issues.

Findings in Serious Care Reviews and Safeguarding Adult Reviews have tended to focus on problems concerning information sharing and communication between different professions (HM Government: WTSC website). In response to this Multi Agency Safeguarding Hubs (MASH) have emerged aiming 'to facilitate information-sharing and decision-making on a multi-agency basis' (SCIE Safeguarding Adults Checklist website). However, according to Perumall (2017) the volume of referrals received by MASHs means each case was just one of many for MASH workers, and when these were not picked up this was perceived by other professions, e.g. Youth Justice Services, as MASH not prioritising their cases. The difference related to how different professionals perceived risk. In Perumall's (2017) research, members of MASH acknowledged that their perception of risk may be lower due to other factors, such as fatigue at the amount they see every day; but also due to the higher threshold for their involvement, which gave the impression to referrers that the information they were sharing was not valued. Shorrock et al. (2020) also found that referrals differed depending on who was referring, e.g. 'the police are focused on crime'; whereas for Sharley (2020) school professionals perceived potential neglect earlier.

When considering adults, there were disparities between professionals about what professional-specific risk could look like, especially when considering the application of the *Mental Capacity Act* 2005. For example, Aspinwall-Roberts et al. (2022) found that there were different perceptions, e.g. a Mental Health nurse may perceive someone not eating, drinking or washing, where a social work practitioner may perceive health practitioners as tending to assume service users lack capacity, which is seen as being about saving money. In their research, Joseph et al. (2019) found that, out of the professional groups, police were most risk averse and social workers least risk averse, with health professionals being somewhere inbetween.

there is a perception that different professionals manipulate the Mental Capacity Act to suit their own agenda. For example, if someone has capacity

Joseph et al. (2019) and Thacker et al. (2019) both highlighted that assumptions are made consistently concerning professionals' ability to work together, i.e. it is assumed that they already know how to do it. This therefore means there is a training gap in areas such as multi agency decision making (Joseph et al., 2019) and professional curiosity (Thacker et al., 2019). Ratcliffe et al. (2020) emphasised the need for raised awareness concerning working together; and Machura (2016) suggested there is a call for joint-training with staff from partner agencies.

Information sharing, thresholds and reporting back: A further challenge regarding referrals not being picked up potentially related to this information not, as a rule, being reported back to the referrer. That is, the referrer may be advised the referral did not meet the required threshold, but it was not, narratively, explained exactly why. Participants in Perumall's (2017) research felt this would be beneficial to share, so referrers were clearer regarding thresholds, e.g. for MASH involvement in future.

Baginsky et al. (2019) highlighted tensions arising when cases were referred, e.g. to Children's Social Care (CSC), but then failed to meet the eligibility threshold for a service. Practitioners in CSC emphasised that this was frequently because they were not receiving enough information or evidence

from referrers, such as schools, to enable them to make a decision. Also the majority of practitioners from both CSC and education services voiced concerns that high thresholds were operating for many early help services, resulting in more cases being 'pushed back'. Baginsky et al. (2019) also found that CSC practitioners did not always report back to other agencies when they were withdrawing support. Other practitioners raised concerns that families not engaging with health appointments led to withdrawal of health services, but without being followed up with welfare related questions by CSC as it should have been.

According to Perumall (2017) practitioners form the Youth Justice Service (YJS) and MASH both emphasised the importance of working together, and that they both wanted the 'best outcome' for the young person. However YJS felt they were 'invisible' to the MASH, and they referred to waiting a long time for a response, with the case then being closed after the assessment was completed without any contact regarding the reason or the outcome. YJS emphasised how they felt the two teams worked separately and not together, and this led to fear that something would go wrong.

Data protection and IT systems: Rees et al. (2021) highlighted that processes and systems, around information sharing, were a continuing problem. Professionals reported being unsure when it was allowable to share information without consent. Concerns were also raised by professionals that the *Data Protection Act* 2018 exacerbated this confusion as they were unsure where it may not apply. In addition the issue of there being different IT systems with different information was also highlighted (Rees et al., 2021; Jahans-Baynton and Grealish, 2022).

Jospeh et al. (2019) related adult safeguarding professionals' difficulties in information sharing to 'professional allegiances' (p.59), and the partnership group most averse to sharing information was found to be GPs. It was highlighted that this was not necessarily the case when relating to child protection, and therefore adult safeguarding professionals' information sharing could potentially learn from this.

Shorrock et al. (2020) found that practitioners were concerned that, outside of MASH, sharing information was more problematic. Also that, within MASH, without a shared IT system they were having to navigate different systems.

Language and knowledge: Carr et al. (2019) highlighted that a lack of shared language between agencies led to more confusion for service users, but Aspinwall-Roberts et al. (2022) found this was also the case for partner professionals' understanding of the language used by other practitioners, e.g. they struggled to understand what 'MCA' meant. Concerns were raised in several studies about the language being used between different practitioners. For example, Rees et al. (2021) emphasised that inconsistent language was used in recording keeping relating to the conflation of neglect and risk. Whereas Perumall (2017) found that words like 'inappropriate' were used in referrals but that this was not specific and therefore meaning was not transferred. Further to this, Perumall (2017) found that those in MASH and YJS did not understand each other's legal remits, and this led to practitioners in YJS potentially having unrealistic expectations of what MASH could actually do without family agreement.

Who is responsible?: A perception that was consistent across the research papers reviewed was that either the police or social care were the responsible agency, or no-one was. For example, Shorrock et al. (2020) highlighted that decision-making being led by the police or social care did not feel equal to all practitioners. This was perceived as either because they owned the MASH system (police) or had managers in the MASH (social care) rather than understanding of legal remits around safeguarding (also found by Machura, 2016). However, Carr et al. (2019) reported practitioners felt that no-one took ownership of the safeguarding process, which was seen as *passing the buck*. Further to this, they

reported a perception among practitioners that other agencies do not do enough, and that blame culture leads to defensive practice amongst practitioners.

As policy suggests, safeguarding is everyone's responsibility (HM Government: MASH website; LGA website) and partner professionals are placed under a duty to co-operate (*Children Act* 2004; *Care Act* 2014). So whilst there is evidence in research studies that this duty is recognised (e.g. Perumall et al. (2017) relating to children and Yoeli et al. (2016) relating to adults), this did not necessarily follow through into the perceptions of practitioners. For example, both Yoeli et al. (2016) and Mason and Evans (2020) found that safeguarding adults, in reality, was perceived to be the responsibility of the social worker.

Aspinwall-Roberts et al. (2022) highlighted a paramedic referring to feeling 'quite vulnerable' when having to assess mental capacity, something they felt social workers were more qualified to do (p.4399). They found overall that practitioners did not want to 'shoulder' the responsibility (p.4401). Likewise, when considering hypothetical safeguarding scenarios practitioners focused on the role of the social worker to intervene to support safeguarding an adult (Yoeli et al., 2016).

Hood et al. (2017) highlighted a further perception amongst partner professionals that social workers were expected to use their authority with service users so as to preserve positive relationships for partner professionals with service users; this was in contradiction to social workers, who also wanted to build positive relationships with service users themselves.

Methodology and methods: Emancipatory Practice Development underpins the research focus of the FPR programme. It emphasises the need for improving practice to be supported by a person-centred approach to access the voice of the person using the service (Deacon, 2022). The term 'service user' is used to refer to anyone who is accessing a service, so in the case of this project *partner professionals* were the service user. A pragmatic approach was taken (Muurinen and Satka, 2020) to access their voice through the use of a qualitative approach in the first instance (Macdonald and Deacon, 2019). This enables the voice of the service user to come through more clearly, and can be followed up by wider surveys that take a statistical focus to test findings on a larger scale.

A qualitative self-completion electronic survey was decided upon as the most appropriate method. Self-completion surveys are beneficial when participants are geographically dispersed, they enable more potential participants to be reached in a relatively short space of time, are free from variability/influence of interviewers, and the cohort felt it was important to reduce the inconvenience on potential participants due to their roles in front line services (Clark et al., 2021). Whilst research into safeguarding is widespread, a specific focus on active social workers seeking the perspectives of partner professionals is relatively unique. Therefore, as the research area is exploratory, the use of a qualitative survey, as well as enabling access to the service user voice, also enabled responses to be driven by the participants themselves rather than the researchers.

Only five open questions were asked, in order to minimise the amount of time needed from participants to complete the survey. These questions specifically related to asking partner professionals to explain their perceptions of duty, risk, expectations of social workers, as well as what they have found helpful and supportive. Through pilot testing it was estimated that the survey should take approximately ten minutes to complete. A link and QR code to the survey were then distributed across practitioner networks, e.g. NESWA, and via cohort members to their own networks.

Ethics: Ethical approval was sought and received from the University of Sunderland Research Ethics Committee (application: 017781), as the academic host of the research, as well as from the NESWA management group.

Limitations: The survey was made available from 31 May 2023 to 16 June 2023 and was shared via the communication networks of each project team member. This limited its reach to the local region and may have limited responses to those connected to the LAs represented in the programme. To ensure confidentiality participants were not asked to name the LA they had experience of, only to confirm they were one of those listed as being a NESWA member (see Appendix 1).

Approach to analysis: Descriptive data is provided concerning the area of practice partner professionals completing the survey operated in. In terms of the open (qualitative) data, a three-phase qualitative thematic analysis was conducted using Braun and Clarke's (2006; and Clarke and Braun, 2013) six-stage framework in each phase: familiarisation, coding, search for themes, reviewing themes, defining and naming themes, and writing up themes. The three-phase approach was necessary as a quality control measure to enable each member of the project team to engage in thematic analysis, to gain research experience and to share out the work of the project.

The data was cleaned and separated into responses from those working with adults and those working with children. In Phase 1 each member of the practice research team was allocated all the data (from either adults or children) to analyse from at least one open survey question. Each followed the six-stage framework for coding and submitted their findings showing how they had come to decisions regarding identification of themes. In Phase 2 an experienced researcher in the project team conducted a quality assurance check, comparing each team member's findings to the original data. Following this, in Phase 3 the same researcher conducted an overall six-stage framework analysis to present the overall findings across the project.

Sample: After the data was cleaned 63 usable respondents were identified. **Table 1.1** below shows seven practitioners had experience with only adults, 30 with only children and 26 covered both. Based on the responses given, participants were separated into two groups: those working with/referring to issues with adults (PP1–33); and those working with/referring to issues with children (PP34–63).

Table 1.1. Responses

Area of experience	Number of responses
Adults	7
Children	30
Both	26
Total	63

The largest partner professional group to complete the survey was those from health (see **Table 1.2** below), but surveys were also completed by partners in education, charities, the police, social care and 'other' organisations.

Table1.2. Area of practice

	Charity	Education	Health	Police	Social Care	Other
Adults	1	0	4	0	1	1
Children	1	5	19	0	2	3

Both	1	1	13	2	0	9
Total	3	6	36	2	3	13

Findings: The findings from the thematic analysis will be presented separately into responses from practitioners who work with adults, followed by those who work with children. Each section begins with what partner professionals perceive as their safeguarding duty, which is then further explored within the themes. The first three themes in each section reflect responses to the questions asked (see Appendix 2) with the fourth theme being specifically identified by either adults' or children's partner professionals.

Adults' themes:

1. Profession-specific 'risk'
2. Transactional communication
3. Professional respect
4. Systemic issues

Children's themes:

1. Profession-specific 'risk'
2. Transactional communication
3. Professional respect
4. A 'consistent approach'

Adult Services responses: Partner professionals referred to either having a direct or indirect duty in safeguarding. Direct duty was towards adults who are seen as 'vulnerable', for example PP1(Charity) referred to this as ensuring 'they do not come to harm'. Others referred to an indirect duty to identify safeguarding concerns and 'refer' them on to the Local Authority. In this role, they referred to supporting other staff members in their organisation to, for example, 'raise concerns' (PP13(Health)) which was referred to by PP19(Health) as 'safeguarding support and supervision to [the] worker'.

Profession-specific 'risk': Almost all partner professionals' responses from those working with adults referred to some form of vulnerability in a person. PP7(Charity), PP24(Health), PP27(Housing) and PP28(Housing) specifically identified this as 'self-neglect', where others reported issues such as financial abuse, disability, health needs, domestic abuse and substance misuse. The majority of respondents were general in their responses, illustrated in how PP27(Housing) responded: 'Self neglect, alcohol and drug… misuse. DV'. Where specific examples of what risk looked like in partner professionals' day-to-day practice, these have been set out in the extracts below.

> *…someone in a care home coming into hospital with pressure sores*
>
> PP2(Health)

> *Financial abuse can be identified via key working sessions around income/expenditure, the need for food parcels and hardship loans. Physical abuse disclosures can come about following changes in our resident's emotional state/behaviour or if support workers notice injuries. Once such example of financial abuse which led to a report, was a resident with a learning disability was spending much of their income on tech for a relative, leaving themselves without*

enough income for food and essentials. he resident was trying to apply for budgeting loans to bridge the gap.

PP5(Supported Accommodation – learning disabilities).

…carers refusing to bring patients to appointments… comments made by patients about their finances or their "friends" or family.

PP15(Health)

A particular example is, a gentleman who had a small fire in his home who wasn't at the property at the time. On entering to inspect found no furniture, no food in the cupboard and a limited way of living.

PP(22)Housing

These are indicative of what risk looks like to partner professionals, underpinned by their own profession-specific perspective, i.e. where they focus on specific issues. Participants from different professional backgrounds observed how they themselves have differing perspectives when it comes to the identification of risk which, according to PP2(Health), leads to them having a 'different priority' to social workers. This was highlighted further by P15(Health) who identified how they felt social workers do not understand the health risks that made their referral a safeguarding concern. Likewise, P19(Health) felt mental health risks were not sufficiently understood by social workers. Professionals from Health and Mental Health specifically suggested they identified higher risks than social workers were able to understand, therefore the social workers were perceived as not recognising the significance of the referral. Professionals from Housing also observed that social workers did not understand risks regarding homelessness.

Referral confusion: Participants reported feeling perplexed as to why cases they were referring to Local Authorities (LA) were not being 'picked up' (P25(Housing)). P14(Health) referred to this feeling like a 'push back' from Local Authorities, whereas P19(Health) felt that social workers did not take up cases because they appeared overwhelmed and not wanting to agree to plans that meant their continued involvement. P7(Charity) highlighted how they experienced different responses to similar referrals depending on which Local Authority they referred to. They also highlighted that whilst threshold criteria remained the same, cases were increasingly being sent back to referrers when in the past they would not have been. P41(Health) referred to the meeting of thresholds as a 'fine line', explaining how it is difficult to know when to refer and when not to. P1(Charity) referred to referrals only being made when they perceive 'serious risk'.

When considering the differences in partner professionals' responses those from a health background tended to expect that once a referral was sent into a Social Worker that this meant the Social Worker would take over, mitigate risks and intervene. However those from a housing profession tended to perceive this as a joint task. What may need to be considered is that those in housing predominantly work within the Local Authority, or organisationally closer to, where the Social Worker is based.

Transactional communication: For partner professionals this was highlighted as being a transactional process, i.e. they provide information and then the lead agency will do something about it. Responses indicated, however, that partner professionals did not perceive feedback as consistent or timely.

The majority of the time we need to chase up the referral to find out the outcome

PP20(Health)

… would like feedback on a referral so my team could understand why no action is being taken

PP24(Housing)

> *Biggest struggle is not getting feedback on outcome of referral, or if we do get feedback is case opened or closed (minimal detail re rationale) and this raises issues in terms of how easy challenge and escalation is- particularly if I have no ongoing direct role with person / family. Contacting SW via telephone successfully is a consistent challenge- lots of back and forth attempts both ends due to demands.*
>
> PP19(Health)

These are reflective of partner professionals seeking to understand why referrals were not taken up or actioned by social workers. This further led to a concern by partner professionals regarding re-referrals, especially when they have not understood the reason for the decline in the first place, or what to do if they wish to escalate their concerns. For example, PP32(Police) highlighted how actually giving feedback 'allows for professional challenges to be made on the decision making process'.

Partner professionals not only expressed a desire to understand why thresholds were not met, but also a desire to be able to engage in dialogue about this and highlight their concerns verbally to illustrate them more clearly.

> *I have found it most helpful when social workers have had time to talk through the safeguarding and inform me of what their next steps are. Unfortunately I would say that I am informed that the safeguarding has been closed/of the outcome of safeguarding for less than 5% of the safeguarding referrals I have submitted, despite ticking the box on the form asking to be kept up to date.*
>
> PP15(Health)

Professional respect: When considering what is perceived as vulnerability, professionals frame this from within their own professional knowledge. This is based on a different depth of profession-specific knowledge to social workers (as set out previously). However, partner professionals reported feeling frustrated that their (profession-specific) concerns were not being taken seriously by social workers. This raises the question as to whether the concern is not shared because: (a) the social worker does not have the profession-specific knowledge to understand the vulnerability; or (b) the social worker takes a different professional view and when this vulnerability is contextualised it is not deemed as high a concern as the partner professional perceives. From partner professionals' perspectives, however, this felt negative.

> *I often feel my professional judgement is disregarded*
>
> PP1(Charity)

In working together effectively in information sharing, partner professionals emphasised the need for professional respect. Partner professionals reported feeling that social workers undervalued their professional expertise. In relation to referrals they highlighted how social workers would not accept the professionals' analysis of risk because, from partner professionals' perspectives, they did not understand the specific complexity of the issue being presented to them, i.e. that social workers did not accept there was a risk. This was highlighted in particular by professionals from health, mental health and housing. PP1(Charity) referred to being 'disregarded' whereas PP26(Housing) highlighted how 'complex people in crisis can be routine for us and we are experienced and confident in what we are doing'. This was emphasised by PP58(Health) who referred to 'awful experiences of not being listened to, not having our views valued or acknowledged, and often quite rude encounters'. What partner professionals found helpful was when social workers took steps towards understanding their

profession-specific concerns, for example when social workers had given some time to trying to understand a medical condition and what risks that presented to the person.

Partner professionals identified further examples that they found helpful, including feeling they were being listened to when voicing their concerns, and seeing social workers taking an open and curious stance rather than coming in having seemingly already made up their mind about what they were going to do. Having a chance to talk through reasons for referrals was seen as being of significant importance to professionals, meaning they could elaborate on information in referrals. It was highlighted that in being listened to and understood this led to shared decision making rather than one professional taking over from another.

> *You treat people the way you are treated and the decent thing to do is listen/show respect and communicate well.*
>
> P20(Health)

Systemic issues: A number of participants observed that there were larger, systemic issues impacting on how effectively social workers were able to do their jobs. P14(Health) identified how problems in differing professional perspectives would be better alleviated at a policy level by bringing together adult and children's services with health and mental health so a genuine multi-disciplinary holistic approach could be taken. P14(Health) highlighted the need for a shared professional forum to ensure safeguarding can be acted on as everyone's responsibility, and to ensure decision-making regarding risks and feedback is clear. P26(Housing) however identified how social workers had 'no resources' which, in adult services, led to issues in not being able to discharge fit patients from hospital beds as community resources were limited.

Children's Services responses: For both those working with adults and those working with children, partner professionals referred to either having a direct or indirect duty in safeguarding. By direct duty, responses tended to be generalised as to 'recognise concerns' (PP44(Health)) in their day-to-day practice, or 'Keeping children safe from harm' (PP35(Education)). Other partner professionals (n=19) referred to an indirect duty to 'refer' to other services, report to an organisational safeguarding lead or to make a referral to children's services. In this respect, partner professionals perceived their key role in safeguarding was therefore to pass on information, for example 'Ensuring that all concerns, disclosures are passed on' (PP33(Charity)).

Many responses also referred to using their own organisational policy and procedures to define safeguarding. This potentially indicates that, from partner professionals' perspectives, 'safeguarding' refers to following procedure, as opposed to meaningful working together. This could possibly also suggest a risk-averse culture in partner agencies, who are defensive and seeking not to tackle risk but rather make sure they do what they believe is expected of them.

Profession-specific 'risk': Similar to the responses of adults' partner professionals, when thinking about 'risk' generic issues were highlighted, albeit briefly, as types of abuse, e.g. physical, sexual, emotional, neglect and topics such as domestic abuse and substance misuse. This is illustrated in the response from one health professional who identifies as having over ten years' experience:

> *Children suffering from all categories of abuse- Physical, emotional, neglect, sexual and risks outside the home*
>
> PP57(Health)

In these responses (n=6) no information was given on how these risk factors were identified or what that particular professional's threshold was. Where specific examples were given, these largely related

to physical signs from health professionals, such as bruising, as well as repeatedly missing appointments.

> *a child with weight loss*
>
> PP16(Health)

> *have unexplained bruising to bodily areas not usually associated with bruising or finger/hand shaped bruises to body*
>
> PP41(Health)

> *dad being verbally abusive to the mam or about the mam*
>
> PP53(Health)

These examples related to what they could observe (n=18) and in the majority of cases these related to signs of physical abuse, with partner professionals referring to 'injury', 'marks', 'bruising' etc. Few partner professionals referred to other signs, such as how to observe potential neglect, emotional or psychological harm.

From education partner professionals' perspectives the risks they looked out for were:

> *unexplained absences from school*
>
> PP36(Education)

> *…signs that give cause for concern or perhaps make you feel uneasy. I had a student submit a piece of creative writing which I was concerned about so I sought* advice
>
> PP38(Education)

These examples are illustrative of profession-specific observations and when considering the concept of risk partner professionals appear to be considering *evidence of harm* rather than *risk of harm* i.e. where some form of abuse has taken place rather than understanding the need for their focus on prevention i.e. what to do before harm takes place. However it is also possible that at the point of referral to the Social Worker the harm has already taken place therefore the threshold has been met, from the partner professionals' perspective. This is indicative of why they may feel concerned that their referral is not taken up because the harm, from their perspective, has happened.

Transactional communication: Partner professionals tended to acknowledge that in order for a safeguarding referral to be considered there needs to be a review of information by social workers to consider it against the threshold for risk. As a first step, however, partner professionals highlighted the importance of having this referral acknowledged by the social worker/Local Authority. This is highlighted by PP33(Charity): 'respond and acknowledge referrals we have made'. As with adults' partner professionals, this highlights how they perceive information sharing as transactional in nature, i.e. we provide information and social workers do something with it. In the case of children it was expected that social workers would speak to the child, speak to the family, provide support and risk assess; this was highlighted by PP36(Education) as 'Checking up on the wellbeing of the student' and by PP38(Education) as to 'act upon any information shared with them and follow it up'.

Partner professionals also felt it was important to understand from social workers if more information was needed and what the outcome of the referral was. PP45(Health) emphasised that they expected social workers to 'clarify any gaps in information or lack of understanding', and PP47(Health) wanted social workers to 'Listen to my concerns, consider them carefully and investigate as necessary'.

A large number of responses highlight the desire for outcomes and information to be communicated to the referrer with a view to giving a rationale as to decisions. Out of the partner professionals, 16 responses referred to requesting that communication should preferably be made, with the referrer to communicate the outcomes as illustrated below:

> *Keep us updated on the progress of referrals and advice on actions going forward*
>
> PP62(Social Care)

This latter point was emphasised by other partner professionals (n=20), i.e. that they saw the role of the social worker was to investigate further, and to undertake some form of risk assessment, as illustrated below.

> *To delve into the concern further and discuss with parents/guardians. To rectify or aim to help the clients to point them to parenting classes, financial support, social workers, support services and also ensure the clients have someone to talk to. We are always hoping for someone to investigate the claims/referral and be able to help the clients as best they can.*
>
> PP41(Health)

There were concerns overall, however, regarding the responsiveness and also the availability of social workers.

> *I find a lot of social workers unavailable, they are not actively involved in the care of clients or are unwilling to share information (ie: when a child goes into foster care, they is not always shared with community practitioners and is difficult to follow up in LAC meetings).*
>
> PP45(Health)

Only five partner professionals' responses referred to wanting professionals to work together to achieve the best outcomes. Health partner professionals tended to expect that the risk was passed on to the social worker, with the expectation that social workers would then take responsibility.

> *That the concern will be fully investigated*
>
> PP55(Health)

> *Protect the child from any abuse and possibly intervene if at all necessary*
>
> PP59(Health)

Professional respect: As with adults' partner professionals there was an emphasis on the importance of respect for other professionals through creating space to collaborate and demonstration of valuing the judgements of everyone. This was highlighted in the need for partner professionals to see a clear plan which everyone has contributed to, in order to share accountability and provide a holistic approach to supporting safeguarding issues for families. In demonstration of respect, good, active listening from social workers was emphasised so that healthy challenge and holistic discussion could take place.

> *Creating an environment where discussion is welcomed and healthy challenges allowed and acknowledge*
>
> PP45(Heath)

Some partner professionals gave specific examples of what they found helpful, e.g. using scales to quantify levels of risk and concern for cross-comparison at later points, rather than having jargon, which is profession-specific.

A 'consistent approach': There are several key issues that partner professionals found helpful. Primarily this begins with what PP37(Education) refers to as a 'consistent approach'. This relates to a range of different areas: consistency in workers; consistent advice; consistency in processes.

For partner professionals, high turnover of safeguarding staff appears to be a large contributing factor in whether they feel supported throughout safeguarding processes. The issue of consistency also arises in relation to the giving of consistent advice in safeguarding, as well as consistency in the use of safeguarding processes. This appears to relate to how safeguarding thresholds are interpreted and employed in practice, with consistency in the approaches to thresholds being something that would assist partner agencies in feeling like there is more clarity. This connects to partner professionals emphasising the need for responses and reports etc. to be timely and concise. There is a consistent view in partner professionals that having the ability to *prepare* before safeguarding meetings, and being given information ahead of time, which is relevant and concise, is a helpful strategy in ensuring everyone is able to contribute effectively and equally. In addition it seems that partner professionals have a strong view that the minutes of meetings being distributed after the event, in a timely manner, to support reflection and challenge where needed. This is illustrated below:

> *Having reports circulated in enough time for me to be able to digest all the information before attending meetings*
>
> PP56(Health)

> *I hope that they share the information as necessary and action this is a timely manner.*
>
> PP39(Health)

Partner professionals also highlighted the perceived unavailability of social workers which left them feeling frustrated (P54) or not being responded to in 'good time' (P60).

Discussion: Serious case reviews and Safeguarding Adult Reviews often highlight challenges in communication and partnership working as contributing towards failures. Despite these being highlighted, e.g. Laming, Munro etc., these problems continue to re-occur. Deacon and Macdonald (2017) suggest this can relate to challenges in what 'partnership' means, as the term is 'inconsistent and there is no "one clear way" to do it' (p.20). This problem can be conceptualised according to Charles Handy's (1976) framework for organisational cultures (cited in Deacon and Macdonald, 2017). A role culture is one that is bureaucratic, with key lines of policy and communication and specialist roles for employees. This can be applied to many of the partner professional organisations that work together to safeguard, e.g. social work, health, police, education etc. Each role has a specific set of criteria (job description) in terms of what is expected of it, i.e. a social worker, a nurse, a police officer, a teacher etc. However, the act of safeguarding is a 'task' where these different roles come together for the purpose of safeguarding (as seen for example in MASHs). Role cultures are often slow to change and have their own profession-specific perspective, therefore when coming together they will automatically apply their profession-specific perspective. Challenges in working together for safeguarding were found in both the literature review and the findings. Deacon (2017) highlights how when considering different professional roles such as health, education, social work, police, housing etc., each one can take a different perspective on the person or issue at hand. This is reflected in the different examples of profession-specific risk given by partner professionals, e.g. weight loss (PP16), unexplained bruising (PP41), not attending appointments/medical needs met (PP16 and PP17). What

is significant to partner professionals (supported also by the literature review) is in how their concerns are responded to by social workers in terms of thresholds for social work intervention. This was demonstrated in confusion that cut across themes as to:

i. whether information provided from partner professionals met social work thresholds;
ii. whether information from partner professionals was understood sufficiently by social workers to inform a decision on thresholds;
iii. whether partner professionals and their professional judgement was fully valued by social workers; and
iv. whether thresholds were applied consistently across Local Authorities.

All partner professionals also referred to the transactional nature of communication with social workers in Local Authorities – an expectation that when information was provided to them that they would do something about it *and* keep the partner professional involved. Feeding back as to why a referral was declined or whether more information was needed was highlighted as significant in both the findings and the literature review. This was illustrated by PP15(Health) as having 'time to talk'.

From the data provided it is evident that partner professionals need feedback so that they can understand what does and does not meet safeguarding thresholds at Local Authorities to initiate social work involvement, and *why*. It is posited that this could reduce the number of referrals if partner professionals understand thresholds for referrals and where something they see as 'serious risk' (PP1) may not present as a holistic risk, or may be something they are seen to be able to manage themselves. Having 'time to talk' things through would enable social workers and partner professionals to understand each other and whether the referral met thresholds. PP18 referred to this as a need for 'close working relationships and excellent communication'. PP44 similarly highlighted how 'improved communication' can help address issues where there is disagreement. When considering practicalities of this, respondents identified elements where it was not good.

What helps? Partner professionals were asked what they had found most helpful in engaging in safeguarding with social workers and the following were highlighted:

- Having 'all the right information' is what leads to positive working experiences (PP4). Feedback regarding referrals that meet thresholds and those that do not is essential for partner professionals to understand when to refer and why a referral has not been accepted.
- Social workers need to better understand the roles of other professionals (PP5). This needs to lie with the organisation, not just individual practitioners, as the turnover of social work staff was raised as a risk to the loss of knowledge of services.
- Social workers need to understand more about mental health and health and housing.

These have been combined with the findings from the data analysis to feed into the following report recommendations.

Report recommendations:

- NESWA to develop training to help both social workers and partner professionals understand what profession-specific risk looks like and to embed professional respect of partner professionals across *all* partners.
- Local Authorities to re-evaluate their policies and practice to ensure they are clear and consistent in applying thresholds for safeguarding intervention.
- Local Authorities to develop approaches in giving specific feedback to partner professionals on referrals, especially those not taken up.

Recommendations for further research

- To explore the differences in perceptions regarding what working together means for Housing departments; and at what point those in Education and Health feel their safeguarding duty is discharged.

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APPENDIX 1

NESWA membership – in alphabetical order

Local Authorities:
Darlington Borough Council
Durham County Council
Gateshead Council
Hartlepool Borough Council
Middlesbrough Council
Newcastle City Council
North Tyneside Council
Northumberland County Council
Redcar and Cleveland Borough Council
South Tyneside Council
Stockton Borough Council
Sunderland City Council / Together for Children, Sunderland

Higher Education Institutions:
Durham University
New College Durham
Northumbria University
University of Sunderland
Teesside University

APPENDIX 2

Qualtrics Survey

This survey is part of a study seeking to understand how partnership professionals perceive and experience safeguarding of children and/or adults. By partnership professionals we are referring to anyone from Education, Health, Housing, Mental Health, Police, Probation, Social Care or any other organisations (excluding social workers) who have current experience related to safeguarding children or adults.

We wish to understand your average, everyday experiences when engaging with social work practitioners concerning safeguarding of children and/or adults in relation to any of the following Local Authorities:

1. Gateshead Council
2. Darlington Borough Council
3. Durham County Council
4. Hartlepool Borough Council
5. Middlesbrough Council
6. Newcastle City Council
7. North Tyneside Council
8. Northumberland County Council
9. Redcar and Cleveland Borough Council
10. South Tyneside Council
11. Stockton Borough Council
12. Sunderland City Council / Together for Children Sunderland

What is the purpose of the study? To support the effective implementation of safeguarding practice, NESWA wishes to understand the issues being faced by partnership professionals across the region. In light of this, practitioner researchers from different local authorities have been engaged, who are currently completing a Facilitated Practice-based Research project with the University of Sunderland. A short, qualitative survey has been constructed to access the views and experiences of partnership professionals.

Previous research highlights that different professions have different cultural perspectives regarding risk and that in order to work together, it is important for social work practitioners (as safeguarding leads) to understand this. This survey represents an opportunity for you to, anonymously, share your experiences so that your voice is heard.

In hearing the voices of our partners, NESWA aim to co-construct appropriate multi-agency training/conferences to share across the region to better improve practice in working together to safeguard. If you would be interested in being a part of this, please email the NESWA Project Manager, simondenny@gateshead.org.uk directly.

Who can take part in the study? Do I have to take part? Any professional who has had contact with any of the 12 Local Authority organisations in this study, concerning safeguarding (excluding social workers). However, participation is entirely voluntary.

What will happen to me if I take part? You will be asked to complete a survey that should take approximately 10 minutes. It is intended that following thematic analysis of the data NESWA will plan a series of workshops/conferences to share these findings to encourage multi-agency collaboration. This will also lead into future research.

What are the possible disadvantages and risks of taking part? Disadvantages are not anticipated as your participation in this research is entirely voluntary. If, however, you become distressed in writing about events please take appropriate action with your employer's occupational health/wellbeing service or access an appropriate health practitioner.
Please be aware that, as your answers are anonymous, any potential risks you identify will not be able to be followed up, therefore we ask you to engage with your own organisation's safeguarding procedures.

What if something goes wrong? If you feel unhappy about the conduct of the study, please contact Dr Lesley Deacon immediately, or the Chairperson of the University of Sunderland Research Ethics Group (details below).

Will my taking part in this study be kept confidential? Yes, you are not asked to identify yourself, any others or organisations, in the survey and only the Facilitated Practice-based Research team will have access to this data. If any personal information is included in error this will be removed by Dr Lesley Deacon before any data is shared with the Team. Only once all the survey responses are combined together and analysed, will any findings be shared with NESWA and the Local Authorities. All raw data collected will be destroyed 12 months after the end of the project.

What will happen to the results of the research study? An anonymised Practice Report will be completed following analysis of the surveys. This will be shared with NESWA and the University. If suitable, the results may also be presented at academic conferences and/or written up for publication in peer reviewed academic journals. At this stage, however, all details, including the identity of the region of the study will be anonymised.

Who is organizing and funding the research? Who has reviewed the study? This research has been developed by practitioner researchers completing the Facilitated Practice-based Research programme ©University of Sunderland. This has been funded by NESWA, the University of Sunderland and the European Social Fund. The University of Sunderland Research Ethics Group has reviewed and approved the study.

Do I have to answer all the questions in the survey? No, you will be able to skip any question you prefer not to answer.

Do I have to complete the survey online? Yes, in order to ensure your anonymity we can only accept surveys completed online.

What if I have some questions about the survey before agreeing to participate? That's no problem, please contact Dr Lesley Deacon for a chat.

Dr Lesley Deacon, Senior Lecturer in Social Work, University of Sunderland (email: lesley.deacon@sunderland.ac.uk, phone: 0191 515 3076)

Dr John Fulton, Chair of the University of Sunderland Research Ethics Group (email: john.fulton@sunderland.ac.uk, phone: 0191 515 2529)

In giving your consent below and entering the survey, you are agreeing to the following:

I have read and understood the study information above I consent to participate in the study and agree that any information I give can be used for analysis.
I will not give any personal/organisational details but that if I do, in error, I agree to these being removed.
I understand that direct quotes from my answers may be used in analysis and in outputs, but only as only in the context of aggregate and analysed data, and not in any way which could be identifying. Only analysed information will be shared with NESWA and the Local Authorities.

- I **AGREE** to participate in this study. (1)
- I **DO NOT AGREE** to participate in this study. (2)

Please confirm you have had experience with at least one of the Local Authority organisations within the North-East of England.

Yes
No
[if no ticked, thank you for your interest in completing this survey however we are only researching experiences of the Local Authority organisations in the North East of England]

Which area of safeguarding do you have experience of:
Children
Adults
Both

How many years' of safeguarding experience do you have?
Less than one year:
1-5 years
5-10 years
10+ years

What is your area of practice?
Police
Probation
Education
Health
Social Care
Charity
Private sector care
Other, please state:

In the following four questions you will be asked to share your thoughts and recent experiences of safeguarding. (By *recent* we mean, approximately the last twelve months.) We genuinely wish to understand what safeguarding looks like from your perspective as a partnership professional, this is not a test of your safeguarding knowledge or practice.
Also, please be mindful not to give any identifying details (if you do by mistake, these will be removed by the Research Lead, Dr Lesley Deacon, before any data is shared).

1. Please explain what you see as your duty regarding safeguarding. For example, please explain how that differs to your other day-to-day duties such as education/health/policing priorities?

2. How do you identify safeguarding risks? For example what kind of experiences have you observed that have led you to make a safeguarding referral?

3. When making safeguarding referrals to social work practitioners, what are your expectations regarding their actions? For example what are you hoping they will do with this information?

4. When engaging with social work practitioners, what have you found helpful/supportive? For example in multi-agency meetings what has helped you feel listened to/make decisions?

Is there anything else you would like to say about your safeguarding experiences with social work practitioners?