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Collaborating across the threshold: the development of inter-professional expertise in child safeguarding.

Abstract

This paper reports on an empirical study of the expertise that different professionals develop in working together to safeguard children. The research involved three key professional groups who work with children: nursing, teaching and social work. The methodology used a clinical scenario and critical incident to explore professional perspectives and experiences of collaboration. Data collection was via semi-structured interviews with a sample of 18 practitioners, composed of pre- and post-qualifying practitioners from each professional group. Data analysis was undertaken through an inductive process, with open coding of transcripts followed by the synthesis of themes into a qualitative framework. The findings identified different elements of interprofessional expertise including assessment and decision-making, responsibility, risk and uncertainty, managing relationships, and dealing with conflict and difficulty. Collaborative activity was found to be shaped by the threshold between statutory and non-statutory services and mediated by the relationship between practitioners and parents. The paper concludes by exploring constraints and opportunities for addressing potential gaps in interprofessional expertise in this area.

Keywords: child protection, child safeguarding, interprofessional working, expertise

Introduction

Expertise is often understood in terms of individual proficiency, denoting a combination of skills, knowledge and practices that allows the expert to demonstrate 'superior performance within a specific domain of activity' (Bradley, Paul, and Seeman, 2006, p. 77). In many sectors, including health and social care, expertise is associated with particular occupational groups, which exert a special claim over activity in specific domains as part of their 'professional project' (Larson, 1977). Once sanctioned by the state, public service professions have gone on to colonise statutory institutions such as local authorities, schools and hospitals, often defining their services they provide and resulting in a compartmentalisation of expertise within professional and institutional boundaries (Own author, 2015). This has proved both a resource and a challenge in domains that happen to overlap these boundaries, of which child safeguarding is a notable example (Lonne and Parton, 2014; Willumsen, 2008; Hughes, 2006). Indeed, the importance of professionals working together in order to protect children has proved to be a longstanding concern in countries where periodic scandals about deaths from child abuse have often highlighted a lack of communication and effective collaboration (Sass & Crosbie, 2013; Laming, 2009; Ayre, 2001). Proficiency in a given field unfortunately does always bring with it the ability to work effectively with others (Anning et al., 2006).

For these reasons, Own author et al. (2016) have argued that child safeguarding work requires expertise not just in individual professional remits but in the collaborative domain of practice that constitutes safeguarding work. They describe 'a domain-specific application of general attributes of collaborative practice', which 'encompasses elements of formal and

tacit knowledge, depends on the ability and experience of the practitioner, and is shaped by their role as well as the jurisdiction in which they have trained and worked' (Own Author, 2016a: 7). In other words, *interprofessional* expertise is developed in response to the experience of working with others as well as the knowledge gained from training and education. Acquiring this type of expertise enables practitioners to tailor their collaborative practice to the uncertain and sometimes volatile conditions characteristic of safeguarding work. The idea of interprofessional expertise places emphasis not only on differences between professional groups but also between pre- and post-qualifying practitioners. As such it has implications not only for policy and practice in the child welfare but also on the training and education of children's professionals. As Own Author et al. (2016: 494) point out, most professional training programmes continue to be uniprofessional in nature, with a lack of opportunity for practitioners to learn "with and from and about each other". Professionals working with children often find safeguarding to be an aspect of practice for which they feel poorly prepared, and the majority of professional groups continue to receive quite basic child protection training (Goldman & Grimbeek, 2014; Polnay, 2000; Rowse,2009). Interprofessional working has been highlighted in many countries as a problematic aspect of protecting children within a broader framework of child welfare provision (Bunting, Lazenbatt, & Wallace, 2010; Hughes, 2006; Laming, 2009; Lonne & Parton, 2014; Hawkins & McCallum, 2001; Polnay, 2000; Raman, Holdgate, & Torrens, 2012).

While taken as a whole such evidence is useful, it suggests that issues with collaboration can be resolved by implementing the right structures, e.g. procedures to ensure that care plans

are coordinated properly, or training to ensure that practitioners understand the roles and remits of others. These assumptions correspond to what Munro (2010) called an 'atomistic' approach to child protection, which would treat collaboration as a technical problem to be solved through compliance with 'best practice' guidelines and procedures. However, a potential source of difficulty with procedural solutions is their lack of attention to the relational dynamics of emotionally laden and often volatile situations, which may disrupt care planning and aggravate conflict within inter-professional teams (Own author, 2014, 2015b; Reder and Duncan, 2003). In her review of the UK child protection system, Munro (2010) went on to argue that an over-emphasis on guidelines and compliance may have had unintended consequences in terms of eroding practitioners' confidence and ability to manage the complexity of their work (see also Ayre and Calder, 2010). This matters because 'the most effective means of intervening in families is to try to provide the breadth of professional expertise that meets the breadth of their needs' (Munro, 2010: 16). In other words, collaboration is a complex phenomenon, i.e. it emerges over time with experience as professionals interact and work with each other. These interactions relate to a specific problem or situation – or 'case' in the parlance of child protection work – but they give rise to social behaviour that is not amenable to prediction or control (Own author, 2015).

Given these thorny issues, what is currently lacking is empirical evidence as to what interprofessional expertise looks like in practice. For example, it is not clear how practitioners from different backgrounds develop specialised knowledge and skills to work with each other on child protection cases, or how this use might vary according to experience, role and remit. The study outlined below seeks to redress this gap in knowledge

by identifying the elements of interprofessional expertise that arise between and across professional groups as they gain experience of safeguarding work.

Method

Research design

The aims of the study were to:

- Explore elements of inter-professional expertise in child safeguarding identified by a sample of social workers, nurses and teachers
- Compare similarities and differences between professional groups and between pre- and post-qualifying practitioners

The Principal Investigator, a social work academic with a background in child protection, established an interdisciplinary research team, comprising of five other academics with professional backgrounds in children's nursing and health visiting (n=3) and education (n=2). Addressing the study's aims required an in-depth exploration and comparison of practitioners' experiences of working together, suggesting a phenomenological qualitative approach. A theoretical framework for the phenomenon under investigation was adopted from Own Author (2016)'s conceptual review of interprofessional expertise in child safeguarding (see Figure 1). The methodological approach drew on two well-known methods of eliciting professional perspectives on a topic: a clinical vignette and critical incident analysis. Both have been used successfully in previous research into expertise and inter-professional collaboration (Fook et al., 2000; Stacey et al., 2014). A clinical vignette seemed particularly suitable given its potential to permit the comparison of substantive knowledge about child safeguarding issues across professional groups. Using critical

incidents enabled exploration in greater depth as to how professionals understood and experienced joint working in their own practice settings. Combining these methods allowed the research team to collect complementary data from a range of professional standpoints.

Sampling

After obtaining ethical approval, a purposive sample of 18 participants was recruited, comprising six practitioners from each of the professional groups as set out in Table 1 below. The purpose of the sample was to ensure equal representation of teachers, social works and nurses, and of pre- and post-qualifying practitioners. The professions selected for this study were chosen as they are key professional groupings involved in child safeguarding. Pre and post qualifying professionals were seen as central to the study since the aim involved exploring the development of expertise. All of these practitioners had current or previous affiliations with the institution from where the recruitment was being carried out, although their jobs and placements were in a range of settings and local authorities, primarily in urban areas. Pre-qualifying students were all in the final year of their course. All participants gave written informed consent to participate in the research.

Table 1: Sample of pre- and post-qualifying practitioners

Social work	*Education*	*Nursing*
3 final year pre-qualifying students (BA or MSW) *Two pre-qualifying social work students had undertaken placements in statutory child protection teams and one in probation services*	3 pre-qualifying students (BEd, BA or PGCE) *The three pre-qualifying teachers were all employed: two in children's centres and one in a private nursery.*	3 final year pre-qualifying students (children's nursing) *These students were specialising as children's nurses and had completed a range of short placements including community and hospital placements*

3 post-qualifying practitioners (5 years' experience) *All three post-qualifying social workers were employed in statutory child protection teams*	3 post-qualifying practitioners (5 years' experience) *The three post-qualifying teachers all had experience in early years and pre-school education. One was currently working in a primary school.*	3 post-qualifying practitioners (5 years' experience) *Two post-qualifying nurses worked on acute children'swards and one was the safeguarding link nurse. The third was a recovery room nurse (children's).*

Data collection

Data collection was through face to face interviews using the vignette and clinical incident approach. All interviews were carried out by the same researcher, an experienced qualitative researcher, on university premises. The first half of the interview was based on questions about a clinical vignette. This was developed by the research team and piloted with practitioners who did not take part in the study; the final version of the vignette and associated questions are included in the online appendix to this article. The second half of the interview was based on questions on a critical incident, from the participants' own practice, which they were asked to select and reflect on before coming to the interview. All interviews were recorded and transcribed verbatim by a third party, who anonymised the transcripts for the purpose of analysis. Transcripts were not checked or verified by participants, as this procedure has been found to have methodological disadvantages that may outweigh the benefits in terms of transcript validity (Hagens, Dobrow, & Chafe., 2009).

Analysis

Analysis drew on the framework developed by Own author et al. (2016) (see Figure 1) and took place in three distinct but interconnected stages to ensure rigour. Firstly, transcripts were imported into qualitative analysis software (Nvivo v.10) and each member of the research team was allocated three transcripts for initial coding. These exploratory codes were then reviewed by another member of the research team, who was from a different professional background, in order to check the definition and interpretation of coding terms against the original data. The second stage of analysis was to compare and synthesise themes across the entire data set. This process took place in a series of research meetings in which themes and representative quotations were compared and discussed. Themes with similar names and meanings were merged and a set of superordinate categories was developed. In the third stage of analysis, two researchers from different professional backgrounds reviewed the quotations under each superordinate theme in order to identify similarities and differences between professions and between pre- and post-qualifying practitioners. Findings were brought together in a final round of research meetings in order to identify key messages and implications for different professional contexts.

Figure 1. Interprofessional expertise in child safeguarding

Ethical considerations

Ethical approval for the study was sought and granted from the Faculty Research Ethics Committee at the University from which the student participants were to be recruited. Participants were given information about the study and had the opportunity to ask

questions about the study before deciding whether they wanted to take part. Agreement to participant was based on informed consent and participants were reminded that they could withdraw at any time during the study. Data was stored and will be destroyed in keeping with the university policy where ethics approval was given.

Findings

From the data, two overarching categories of inter-professional expertise were identified: 'Conceptualising practice' and 'Managing relationships'. These categories drew together the key themes which arose from the accounts of social workers, teachers and nurses about their experiences of collaboration. The thematic analysis is summarised below in Figure 2, which shows how the elements constituting interprofessional expertise were grouped within each thematic category.

Figure 2. Elements of interprofessional expertise

Conceptualising practice

The first category of themes concerned the ways in which participants conceptualised their interprofessional practice, which included the requisite knowledge and awareness to do safeguarding work, how they understood their responsibilities, undertook joint assessments, made appropriate decisions, and managed risk and uncertainty. Four themes

contributed to this category and captured the ways in which participants conceptualised their interprofessional practice.

The first theme, *'Knowledge and awareness'*, related to participants' knowledge and included understanding the signs and indicators of child abuse, awareness of protocols and procedures, knowledge of other professionals' roles and remits, and references to training and education. One of the main differences between pre- and post-qualifying practitioners was the extent to which connections were made between different forms of knowledge. Pre-qualifying practitioners tended to focus on one area of knowledge and use this as the basis for action, referring to statutory guidance such as 'Working Together', or to well-known cases of child abuse:

> *'The eating, that's quite worrying, especially after what happened to Daniel Pelka, so why is she eating other children's snacks?'* (Pre-qualifying social worker)

In contrast, experienced practitioners skilfully linked their understanding of indicators of child abuse, such as the nature of a child's bruising, with other factors that were not known, such as domestic abuse or parental mental illness, and tried to adopt a holistic perspective on how they followed up their concerns.

Differences were also apparent the ways in which practitioners from different professions exercised their knowledge. For example, nurses and social workers referred in a specific and detailed way to the mechanisms for dealing with concerns, whereas schools and early years settings seemed to have a much more flexible approach to recording and discussing issues

of concern before the decision was taken to involve other agencies. In relation to concerns about young children, all three professional groups talked about the prominent role of health visitors. Children's nurses, particularly those working on hospital wards, appeared to possess a sound knowledge of internal safeguarding processes but had more limited knowledge of what transpired outside healthcare settings and other health professions.

Assessment and decision-making was a second theme arising as professionals across groupings conceptualised their practice in relation to safeguarding. Making decisions was often underpinned by the awareness of who to contact if practitioners were concerned about a child. For teachers and nurses, the advice of other professionals such as social workers or health visitors was generally sought to help them decide whether an allegation or concern met the threshold for child protection. For pre- and post-qualifying social workers, the main reason to consult other professionals was to seek information they needed to make an assessment of risk, which would largely occur within their own agency. However, post-qualifying social workers would sometimes consult other professionals for advice, i.e. what they thought about the risk, rather than just obtaining information. Nurses mostly referred to other health professionals (doctors, health visitors) for guidance as well as from safeguarding leads from their own profession. For teachers particularly, the decision of whether to refer to child protection services was fraught with potential repercussions if concerns proved unfounded:

> *'For something like this situation if you jumped in, both feet first, and rang them yourself and hadn't got enough evidence then you could be highlighting a family that actually hasn't got a major child protection problem' (*Post-qualifying teacher)

The quote above illustrates the way in which the assessment of risk was seen partly in terms of implications for the relationship with parents. This issue was also connected to a third theme, *responsibility*, which concerned how professionals perceived their responsibility for identifying and following up concerns. Social workers noted their clearly defined duties, which included as they saw it taking the lead in coordinating multi-agency plans, while nurses had recourse to tightly prescribed internal processes. Teachers on the other hand viewed their role in relation to safeguarding as being less precisely defined. Such a view appeared to permit them a degree of discretion in how to respond to a given concern and how to interpret their role in the child protection network. Since teachers saw their primary responsibility was to the child, they often found themselves risking the ire of parents by involving social workers. On the other hand, since teachers often had a longstanding relationship with children and their parents, they sometimes found themselves acting as mediators, explaining the CP process to parents, calming and reassuring them during difficult meetings.

More experienced social workers saw their statutory role as conferring accountability for outcomes, which in turn allowed them to be quite assertive and persistent in chasing up other professionals for information. One social worker even spoke of putting herself at some personal risk in an effort to safeguard the welfare of an unborn baby, whose parents were drug users:

> *'I went to the house a lot and sometimes I went alone which I shouldn't have done because it was too risky but I had no other, no one else to go with. Say the midwife wasn't available, the police didn't really want to come every single day, so sometimes […] I went and did it just because I was so worried about the baby being born.'* (Post-qualifying social worker)

What is apparent here is that the social worker *felt* responsible and this appeared to increase the risks she was prepared to take. Other professionals (talking about other cases) also felt that their personal safety was compromised at times, e.g. when attending meetings at the council offices or when making referrals from a day care facility located in their own home. For professionals with more experience, a sense of responsibility for children's outcomes seemed to lead them beyond what was procedurally required of them, whether this meant doing a home visit alone rather than with a colleague, or assertively following up their concerns with other agencies. One social worker referred to the 'low down and dirty way' of persistent ringing or simply turning up at schools and GP surgeries. On the other hand, teachers often complained that social workers were themselves difficult to contact and not always prepared to share information. In this respect, uncertainty about risks and thresholds often translated into a sense of urgency to find out 'missing' information or to seek advice from specialist practitioners. This fourth theme, *risk and uncertainty,* was highlighted particularly by teachers and nurses, who were often unsure about whether concerns were sufficiently serious to merit a statutory referral:

> *'Unwashed clothes, you know, is it just that this child just gets really dirty all the time 'cos he likes messy play and they're stained because mum can't get the paint off, or are they coming in smelly and actually unwashed?'* (Pre-qualifying nurse)

The above quote illustrates the underlying ambiguity of what might seem clear-cut concerns – here to do with the children being sent to school in dirty clothes. Since doing nothing is not an option even when there is a lack of certainty, one response is to document and share information without making a judgement on its relevance:

> *‘I just record everything even if it's nothing. If the parents saw it they probably wouldn't be happy but as long as I know we're covered.’* (Post-qualifying teacher)

On this basis, recording had the dual connotation of preserving information that might gain relevance but would also ‘cover’ the agency if child protection services become involved later on. The quote also illustrates the relational context to risk assessment, e.g. parents reacting badly when they find out teachers have been keeping records on them, which points toward the second major category of themes.

Managing relationships

The three themes categorised under ‘managing relationships’ concerned practitioners’ experience of relationships in safeguarding work, their communication with other professionals as well as with family members, and dealing with conflict and disagreement. The first theme of *relationships* arose in a number of interviews that considered how interactions between professionals were influenced and mediated by the relationship that each professional had with the parents of the child(ren). Nurses tended to regard empathy and trust as the building blocks of a good working relationship, which stemmed from the medical model of care and treatment and was generally short-term. Nurses therefore placed value in being open with parents about what actions they were going to take and why. For example, a post-qualifying nurse remarked that ‘wording was important’ and that ‘part of nursing is learning through experience how best to explain things to parents’. Teachers, on the other hand, were conscious of the everyday and often long-term nature of their contact with parents, which required them to be seen as approachable – ‘the fluffy

person who looks after your child' as one pre-qualifying teacher put it. Both teachers and social workers remarked that parents tended to have a more positive relationship with the former than with the latter. This meant that teachers sometimes performed a mediating role between parents and child protection services. On the other hand, teachers worried about the effects of a referral to child protection services on their relationship with parents, which in turn shaped the role they wanted social workers to play:

> *'In the core group meeting when things get a bit unfriendly, my expectation is that the Social Worker takes this on.'* (Pre-qualifying teacher)
>
> *''Where there has been an abuse within that family, of whatever kind, I tend to keep the relationship. When it's not proven or it's not there it goes out the window!'* (Post-qualifying teacher)

As these quotes illustrate, there was little difference between pre- and post-qualifying teachers in this respect, since both sets of practitioners expressed concern about the impact that a child protection referral would have on their relationship with the parent. As discussed below, the expectation that social workers bear the brunt of parental defensiveness and hostility led to some tensions and conflicts being reported in these interprofessional networks.

The third theme of 'managing relationships' was around '*conflict and difficulty*'. As suggested above, one such difficulty emerged from the idea that statutory social workers should acts as an 'authority figure' to set boundaries and allow other professionals to maintain a more supportive role. This was generally not appreciated by social workers, who were determined to build and maintain their own relationship with parents. As highlighted

in the quote given above, the consequences might be worse for the referring professional if the investigation does *not* disclose any concerns about abuse. In such circumstances, there is no longer a statutory role for the social worker and therefore no supportive role for the teacher, who is instead held responsible by the parents for the stigma of having been investigated. Interestingly, none of the practitioners (pre- or post-qualifying) reflected on how such experiences might affect their overall approach or that of other professionals to risk and thresholds in such cases. Nor was the relationship with the child given any prominence by practitioners; instead, the idea of being 'child-centred' was a way of navigating the relational dilemmas that arose when concerns about child abuse had to be addressed.

Despite the potential for disagreement and conflict, practitioners generally valued interaction with other professionals, particularly face-to-face communication that helped promote dialogue and build mutual respect. '*Communication'* was therefore the third theme within 'managing relationships'. Specific relationships with practitioners who were known and trusted also made it easier to share and obtain information. For teachers and social workers, concerns about confidentiality were cited as a stumbling block to getting information from each other. Conversely, teachers and nurses sometimes mentioned liaising with health visitors to help them decide whether a referral was necessary, and this did not seem controversial in terms of confidentiality:

> *'You'd want the Liaison Health Visitor to tell you what was being done for the family or that something was being done. […] If it wasn't then you would*

> *move onto a social work referral depending on if it's needed'.* (Post-qualifying nurse)
>
> *'It was almost like you got rope and you ringed round all the people and you managed to get them together at a case conference and it was only then that they would most usually verbally give information'* (Post-qualifying social worker)

These excerpts highlight how collaboration and communication was shaped by a shared preoccupation with the threshold between universal and specialist child protection services. Information sharing was seen as unproblematic either side of the divide but fraught with difficulty across it. Such difficulties were almost always associated as practitioners saw it with a lack of proper awareness or communication on the part of the other agency. Multi-agency meetings were generally seen as helpful in terms of enabling information to be shared or dialogue to take place, but sometimes served to exacerbate underlying conflict and disagreement.

Discussion

Conceptualising practice and managing relationships were found to be two overarching categories of interprofessional expertise in the accounts of social workers, nurses and teachers. Differences between the professional groups were often apparent and seemed connected to two key issues. The first was the differential location of professions in a tiered structure of child welfare provision (see Own Author, 2015; Hardiker et al., 1991). In this study, teachers and nurses were operating in universal tiers of provision (schools, GP surgeries and hospitals) and were generally referring 'up' to specialist child protection services mainly staffed by social workers. Since access to specialist services involves meeting

statutory ‘threshold’ criteria, much of the interprofessional activity reported by participants seemed to be focused on gauging potential indicators of abuse in relation to those criteria: what might be termed ‘collaboration across the threshold’. The perspective of professionals making (or considering making) referrals could be expected to be different from those receiving and dealing with them, and this was reflected in themes such as ‘assessment and decision-making’ or ‘responsibility’ in the findings. The second key issue was the social and institutional context of professional involvement with children and families. In some respects, this was linked to the tiered structure mentioned already, in that parents would often have a longstanding relationship with the school or GP surgery to which they regularly took their children, whereas their contact with child protection agencies or hospital wards would usually be more sporadic. However, this was not the only contributing factor. For some children, involvement with social care services could be frequent and even long-term, while the stigma attached to child protection was not experienced by other professional groups. Particularly for teachers, collaborating across the child protection threshold had social consequences that rippled out into the network of professional relationships around the child, and this was reflected in the themes around managing relationships discussed above, including conflict and difficulty.

In considering the development of expertise, the findings shed some light on how professionals learned from the experience of collaborating with others. This was especially evident in themes around the conceptualisation of practice; post-qualifying practitioners seemed to take a more holistic view of concerns, seek advice rather than just information from other professionals, and were more confident about expressing uncertainty in their

assessment of risk. Experience also seemed to impart greater assertiveness in terms of following up concerns rather simply documenting them. Interestingly, the literature on expertise does not have much to say about confidence, focusing instead on what combinations of formal and intuitive knowledge are demonstrated at different stages of professional development (see Own Author, 2016a, for an overview). Yet confidence has been found to be a key issue in child protection, both for individual practitioners, who may need to guard against overreliance on their initial judgements, for example, but also for organisations, whose decision-making and risk management strategies are affected by political and societal pressures (Own Author, 2016; Munro, 2010).

In the other main category of themes, the findings were less informative about how expertise developed in managing relationships. No clear-cut differences were noted between pre- and post-qualifying practitioners, who seemed to report and experience similar issues. In some respects this is unsurprising, given the emphasis on 'carving certainty from uncertainty' (White, 2002: 433) in the ambiguous and complex terrain of safeguarding. Practitioners in universal services have often reported safeguarding to be a challenging aspect of their practice and for which only basic training is provided either at pre-qualifying or post-qualifying level (Tarr et al., 2013; Goldman & Grimbeek, 2011; Polnay, 2000; Rowse, 2009). It is therefore to be expected that expertise would develop in the primary tasks of identification and referral, rather than on dealing with psychosocial dynamics, and this was demonstrated to some extent in the findings reported here. Moreover, the type of collaboration explored by participants in this study broadly conforms to what Ovretveit

(1993) called 'network associations', i.e. groups of professionals who come together to solve complex clinical problems in particular cases but who are neither co-located in teams nor share any lines of management. A particular feature of child protection networks, in contrast to interprofessional care in health settings, is the lack of continuity in the composition of these networks, and the absence of a clinical lead to substitute for the lack of unitary management (Own author, 2016b). While risk assessment and coordination of protection plans are usually the domain of specialist social workers, they have little authority over the contribution of other professionals and may even perceive that they have a low status in the 'team around the child' (Own Author, 2016c). Such networks would seem to offer comparatively little scope for the reflective practice and containing environments that are conductive to relationship-based forms of practice (Ruch et al., 2010).

The findings also point to an aspect of interprofessional collaboration that arguably does not receive enough attention in the child protection literature, namely the problem of contingency. In policies and guidance, interactions between professionals are part of a rational-technical system geared towards assessing various kinds of need and risk, and matching these to appropriate interventions (Own Author, 2012). As such, it is assumed that collaborative activity can be directed from a position 'outside' the immediate context in which professionals need to work together, for example by providing the latter with clear roles and responsibilities, the opportunity to build trust and mutual respect, and 'fostering understanding between agencies' through joint training (Atkinson, Jones & Lamont, 2007). Yet the relational dynamics described by participants were not determined by protocols but

instead emerged from a constellation of factors in particular situations. In other words, there was no 'outside' position from which a manager or trainer could have directed some pre-determined pattern of interactions, which one might term 'the relationship' (see Stacey, 2000, for a discussion of this point in relation to systems). The onus instead was on professionals to work out what kind of conversation or dialogue might serve them best in the here and now.

The problem with regarding relationships as 'things' rather than as a way of thinking about interactions was illustrated in participants' approach to threshold judgements. A preoccupation with thresholds has long been noted in child protection (e.g. Brandon et al., 2008; Platt, 2006) reflecting the view that abuse is a socially constructed phenomenon rather than a scientific 'fact' to be agreed by neutral and objective observers (Dingwall, Eekelar and Murray, 1983). In such cases, the involvement of professionals from different agencies means that multiple thresholds co-exist and often refer to different kinds of decisions. For example, a teacher who makes a child protection referral has made a 'positive' threshold judgement irrespective of whether the ensuing investigation reveals a substantiated concern about abuse, and may be dealing with the consequences of that decision long after the case is closed. In the findings there was evidence that once the boundary to CP has been crossed there was a tendency even for experienced practitioners to retreat into mono-professional siloes in the face of any ensuing difficulties. Again, a technical solution to such problems would be to reiterate the need for professionals to speak a 'common language' and introduce procedures to control professional practice, such as standardised assessment frameworks (White, Hall and Peckover, 2009). Yet such

approaches somewhat miss the point, which is that practitioners will interpret the rationale for such measures differently depending on their role, remit and professional background. For example, social workers, whose statutory role confers responsibility for coordinating services but no managerial authority over other professionals, might have reason to believe that it is 'their' threshold that matters and procedures are necessary to overcome resistance from other professionals, e.g. to sharing information or agreeing to provide a service. Teachers, on the other hand, might see them as a means of overcoming the resistance of social work agencies to accepting their referrals. Procedures establish a framework for collaboration but are unlikely to control how interprofessional relationships are experienced; instead, patterns of interactions emerge unpredictably as practitioners interpret what other practitioners are saying to them in particular situations.

It has been suggested that effective child protection work requires practitioners to be attuned to emotions (one's own and those of others) and the emotional toll of the work has been connected to more widespread professional and institutional anxiety (Munro, 2009; Ferguson, 2005). Again, most of this literature concerns social workers rather than other professionals. In this study, three post-qualifying professionals – one social worker and two teachers – referred directly to feelings of personal endangerment, which perhaps encapsulates the risk perceptions that underlie silo thinking in what McCusker and Jackson (2015) call 'care-group cultures'. Although none of the nurses who were interviewed considered their personal welfare to be at risk, there is evidence that nurses do experience high levels of hostility and violence in the workplace (Jackson et al., 2002), while health visitors have also reported concerns about personal safety, for example in cases of domestic

abuse (Frost, 1999). In this context, the emphasis on protocols and procedures for inter-agency collaboration may serve a parallel function of coping with the anxiety engendered by emotionally distressing work (Menzies, 1988) as well as distributing responsibility for decisions about risk (Own author, 2015). These issues point to an important aspect of expertise in terms of recognising and reflecting on the unconscious group processes and unintended dynamics that affect interprofessional networks in complex situations. There may also be scope for programmes to develop and consolidate such 'hidden interpersonal skills' (Rawlings et.al.,2013,) while engaging with the tensions arising from specific data-identified challenges such as conflict management, risk and threshold decision-making. Interprofessional expertise may then be valued as a dynamic learning experience.

The study had certain limitations in terms of scope and methodological approach. Sampling was purposive and only a small number of practitioners could be recruited in each group of interest. Data collected from participants cannot therefore be seen as representative of these groups. Furthermore, only qualitative data was collected and this should be seen as ideographic rather than generalizable, i.e. practitioners gave an account of their own experiences and attitudes, which may or may not be shared by others. The interprofessional make-up of the research team did enhance the analysis of interview data, in the sense that different interpretations could be triangulated and implications explored for each professional group. However, it is still possible that the viewpoint of one or other profession was not given enough prominence in the final analysis. Some form of ethnographic data, such as the observation of interprofessional meetings or joint home visits, might also have

helped situate the findings in the context of lived experience and bring out the everyday as well as 'critical' elements of interprofessional collaboration.

Conclusion

In summary, this study has reported qualitative findings on the development of expert collaboration in child safeguarding work, drawing on the accounts of social workers, teachers and nurses. Expertise was linked to two thematic categories: how professionals conceptualised their collaborative practice and how they went about managing relationships. In this respect there was evidence that practitioners did develop expertise in terms of working together to assess and understand risks to children, and that collaboration was shaped by statutory thresholds embedded into the tiered structure of services. When it came to expertise in managing relationships, there was less evidence of differences between experienced and less experienced practitioners. In part, this may point to the consequences of perceiving (inter)professional work as a technical activity, where expertise is understood in terms of formally codified forms of knowledge that can be shared according to a 'sender-receiver' model of communication (Stacey, 2000). Addressing this gap in expertise would arguably encompass an understanding of the psychology of communication, the significance of emotions and the interdependence of relationships (Ferguson, 2005; Reder and Duncan, 2003). We conclude that such issues remain a key area for training, education and further research in this field.

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