

Enhancing Safe Practice at the Interface between Hospital Services and Children's Social Care

Funding of £170k has recently been gained from the National Institute for Health Research to enhance the safeguarding of children at the point of discharge from hospitals. A SPRINT approach will guide the design work. The research team includes:

- Suzanne Smith (Safeguarding manager, Pennine Acute Hospital Trust and founding Chair of the National Safeguarding Children Association for Nurses)
- Sue White (Professor of Social Work, Birmingham University)
- Dr. Geoff Debelle (Designated Senior Doctor, Birmingham; GMC paediatric advisor)
- David Wastell (Professor of Information Systems, Nottingham University Business School)

Background

Secondary health care should provide opportunities to prevent children returning to unsafe situations, or to alert other agencies to potential dangers, but there is strong evidence that clinicians under-report child protection concerns and that thresholds for reasonable suspicion are highly variable. Lupton et al (2000) found that clinicians in Emergency Departments believed that other agencies and professionals had unrealistic expectations of their role in child protection work. Workload pressures, ambiguous physical signs and the lack of wider information on the child and the family were seen to limit the role that staff could play. In their review of serious case reviews (SCRs), Brandon et al (2009) note that a third of the 40 children studied had a history of missed health appointments; six had been admitted to hospital, one child nine times, and 18 had at least one attendance at ED.

The persistence of failure to recognise children at risk and intervene appropriately in hospital settings is all the more disquieting given the plethora of reform initiatives rolled out since the death of Victoria Climbié (Laming 2003), including the establishment of Local Children's Safeguarding Boards and increased regulation and audit of child protection responses. Improving information sharing between agencies is emphasized in these reforms, resulting in a variety of complex forms and processes, often embedded in IT systems. Although expounded with strong claims that they would prevent future tragedies, the death of Peter Connelly (Baby P) showed many of the same system failures, especially at the interface with secondary health care.

Within children's social care, there are promising signs of growing interest in more systemic solutions, focused on human factors and human-centred design. Within the NHS, systems approaches have a longer history and initiatives based on these principles have seen significant advances over the last decade. Patient safety is the subject of a high profile NHS initiative, Patient Safety First (PSF). There has been a reconceptualization of clinical risk focusing on latent 'error provoking conditions' which create 'accident opportunities' (Reason, 2000). It has become increasingly recognised that most harm to patients is not deliberate, negligent or the result of serious incompetence. Instead, harm more usually arises as an emergent outcome of a complex system where typically competent professionals and managers interact in inadequate organisational configurations. Although these developments have begun to address the safety of children presenting in hospitals, PSF focuses exclusively on 'in hospital' threats, not the extra-mural risks to which the children are usually exposed,

and there is general concern that protecting the welfare of children is insufficiently embedded within the thinking and practices of acute NHS trusts (Kennedy, 2010).

Much research on patient safety to date has also focused on a single clinical environment, or organisational setting. There has been a relative neglect of threats to patient safety arising across settings, or where the decision-making depends on a dispersed network. Further complexities arise from the need to pass what might be unclear, speculative and ambiguous information across service boundaries. Knowledge sharing throughout child health and social care is thus both 'slippery' (difficult to codify) and 'sticky' (difficult to share across boundaries), not readily responsive to simplistic exhortations to 'share information' (Swan and Scarbrough, 2001).

Project Objectives and Methods

The overall aim of the project is to design a safeguarding culture for the hospital environment that will facilitate the detection of children at risk of abuse and support protective actions before discharge, including collaboration with external agencies. Specific objectives include:

- the development of a rich understanding of why diagnostic failures and communication breakdowns occur;
- the design of a suite of integrated interventions for promoting a positive safety culture, following a user-centred approach;
- the evaluation of the effectiveness of this package, including its generalizability across sites.

The project broadly follows a SPRINT approach, and is currently embarking on Phase 2, "Understanding Process Context". Being at an early stage, we can only outline the broad plan of action. First and foremost, the approach has been strongly informed by research and theory, key elements of which were reviewed in the previous section. In particular, the team has followed a systems approach, focusing on latent 'error provoking conditions' rather than blaming individuals (Reason, 2000). The project team recognised that only a deep understanding of human, social and organisational challenges will afford effective solutions. This accords strongly with the need for ethnographic research as enunciated by SPRINT. SPRINT also requires that current processes be fully understood, and the team has accordingly investigated the efficacy of extant patient safety initiatives in the Trust. This has shown that despite the existence of clear clinical guidelines, practice varies across the Trust sites, and even within specific services.

At the time of writing, initial design work is underway on an integrated package of safeguarding measures aimed at detecting the risk of harm to children when (and hence if) they leave the hospital. This is following a user-centred, prototyping approach, as SPRINT recommends. The package incorporates various elements from PSF, in a suitably adapted form, including the use of 'walkrounds' by senior staff – *getting them out of their offices and meetings and into the heart of the real work*. A "whole systems" approach to the analysis of "safeguarding incidents" is also being developed, focusing on latent conditions alongside procedural failure, as well as an electronic reporting tool for recognising and reporting potential safeguarding risks accurately and promptly to relevant professionals from other organisations, disciplines and agencies. A co-mentoring system is also proposed to provide feedback on cases where a different intervention might have benefitted the child. This will be piloted in A&E, led by senior practitioners. Auditing of records will be part of this, providing feedback when standards are not met.

Moving forwards, two further research phases are proposed, each characterised by intensive, user-centred design making use of mixed qualitative methods (e.g. interviews, non-participant observation of everyday practice, design workshops) to bring the design of the various instruments in Pennine to completion. Table 1 summarizes the current status of each element of the package, the research methods needed to complete the design and the primary outputs. The second design cycle will begin once the package has been developed focusing on its evaluation and refinement. This will include interviews with clinicians and managers, audits of cases and critical incident analysis to determine the impact on decision-making.

Table 1

Intervention	Status	Research methods	Primary output
Walkrounds	Prototype being piloted	Observation for one month Interviews with senior staff	Revised walkround protocol and good practice guidelines
Systemic incident analysis	Prototype system being designed	Retrospective file research; Interviews with senior practitioners involved in the cases above	Revised protocol/methods and training materials; Case studies.
Electronic reporting	Paper systems: including referral forms; Web-based prototype.	Observation of practice and interviews with key staff in A&E, paediatrics, antenatal. Interview referral team managers, in each of 4 local authorities in Pennine's catchment User-centred design workshop	Structured electronic reporting tool for internal and external referrals
Co-mentoring and auditing	Pilot system in A&E	Observation of training of co-mentors in pilot study User-centred design workshop	Protocol and training materials; Case studies

In the final phase of the research, the transferability of the safeguarding package will be evaluated by pilot trials in two further sites: Birmingham Heartlands and Solihull Trust (BHST) and Birmingham Children's Hospital (BCH). Both of these sites have experienced adverse safeguarding incidents and clinicians are enthusiastic about piloting the PAHT materials. This transfer will be facilitated by Dr Geoff Debelle, who will identify specific settings within the hospitals to trial the approaches. The outputs of this phase will be combined to produce a "transition package" combining all the documentation required to implement the various interventions at a new location. At each site, detailed discussion will take place to adapt the package to local requirements, to develop an agreed implementation plan, and to identify useful local innovations to be incorporated into the package.

References

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