

The Early Intervention Safeguarding Nurse Pilot: an integrated model of working

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Abstract

Some of the most vulnerable children will need co-ordinated help from health, children's services and other agencies. Co-ordinated and joint working hinges on effective communication at all levels. Evidence shows that direct verbal communication is a more effective way to share concerns and that this should be followed up by written information. Yet barriers persist that prevent this from happening. Integrated health and social care teams are purported to break down professional and communication barriers. This paper reports on the evaluation of a pilot integrated model of health and social care in the North West of England. Such models can work and produce positive outcomes for children and families, but require full commitment from all parties. There are principles that need to be in place for this integrated model to achieve its aims and objectives, such as a robust governance framework that specifies the roles and responsibilities of each agency, managers and practitioners. Despite the model achieving its aim, the project was not as efficient as it could have been due to the lack of an integrated information technology system.

Key words

Integrated working, information sharing, evaluation, governance, children's services

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No potential competing interests declared.

Introduction

Safeguarding and promoting the welfare of children, and in particular protecting them from significant harm, depends on effective joint working between agencies and professionals that have different roles and expertise (DCSF, 2010; Cleaver et al, 2009). Individual children, especially some of the most vulnerable children and those at greatest risk of harm and social exclusion, will need co-ordinated help from health, children's services, education, the voluntary sector and other agencies (DCSF, 2010). Co-ordinated and joint working hinges on effective communication at all levels, from operational to strategic (DCSF, 2008).

Since the 1970s, most reviews of child abuse deaths have shown that failure to communicate and a reluctance to share information have been key factors in child deaths (Brandon et al, 2008; Laming, 2003; Laming, 2009; Mainey et al, 2009). Equally, when information has been shared it has been hampered by a lack of clarity and problems of interpreting that information to make valuable decisions (Brandon et al, 2008). Another key issue is lack of agreement between workers and professionals on a course of action (Brandon et al, 2008).

Evidence shows that direct verbal communication is a more effective way to share concerns, followed up by written information (Reder and Duncan, 2003; Brandon et al, 2008). Written and electronic information without verbal follow up may lead to information being diluted or misinterpreted. Regardless of extensive use of information technology, communication has two strands – information and interaction. Face-to-face communication has been demonstrated to be the best way of achieving this (Jones, 2008; Quirke, 2008). Despite national guidance on information sharing, the fear of breaching patient confidentiality means that poor information sharing persists (Datta and Hart, 2007; DCSF, 2008).

Following the inquiry into the death of Peter Connelly in 2007, the practice of integrating health practitioners in social care

teams in order to dissolve professional and communication barriers has been emphasised (Laming, 2009). Lord Laming recommended that 'a named, and preferably co-located, representative from the police service, community paediatric specialist and health visitor are active partners within each children's social work department' (Laming, 2009: 88). This approach often requires health practitioners to be co-located, report to and be managed by children's services managers. Collaborative working has been successfully tested by children's district social services in Southwark, London (Whiting et al, 2008). However, its model – the health specialist initiative – identified that when health visitors worked in children's services their clinical knowledge, over time, became diluted and managers had difficulty providing the entire supervisory needs of the health worker (Whiting et al, 2008). Clinical supervision and governance is therefore an area that needs to be well thought through when considering setting up integrated models of working.

This paper is a description of a model of integrating a health visitor, the early intervention safeguarding nurse (hereafter called the nurse), within the early intervention team in Stockport's children's services. This team completes initial assessments on children referred to children's services to determine if a child is in need and requires additional support (DCSF, 2010). The paper will highlight the principles for establishing integrated social-health care teams for each agency. It adopts a managerial evaluation framework, which will be useful for commissioners and providers when considering designing and evaluating quality, innovative and cost-effective services (DH, 2010).

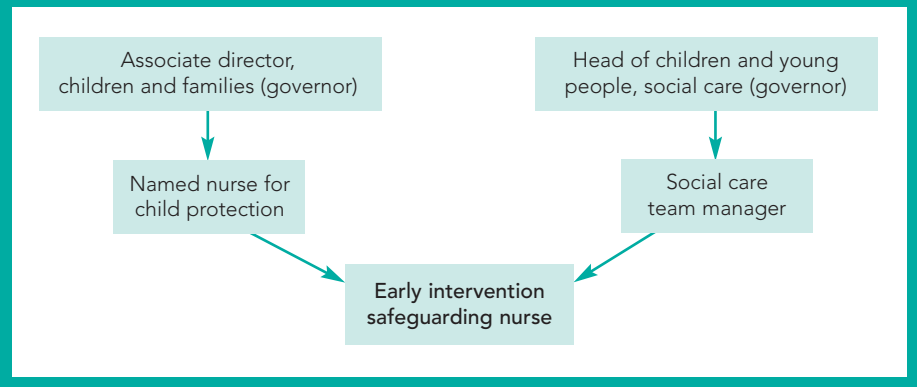
Project background

A local commissioner's review in 2010 of the safeguarding children function of Community Health Stockport (the provider arm of the primary care trust) identified a health visitor and school nursing perception that the numbers of children at greatest need

were increasing, while children's services thresholds had been raised. Health practitioners felt they were 'holding' more families who were previously supported by children's services. Community health practitioners observed that social workers did not feel the need to work with vulnerable families if a health visitor or school nurse was involved. Moreover, health visitors felt they were being used as replacement social workers. Children's services were also feeling the pressure of increasing referrals from health practitioners for initial assessments. Social workers felt they received more referrals requiring specialist health knowledge, hence requested dedicated health expertise.

In order to address these issues, Community Health Stockport invested funding into developing an integrated model of a specialist community public health nurse (health visitor or school nurse) within the children's services early intervention and family support service. The pilot was for a 12-month period. The purpose of the project was to provide health advice and knowledge for children's services, health input to assessments, and act as an advocate for health visitors and school nurses who had concerns over referrals to children's services.

Figure 1. Governance framework and lines of reporting



Governance and accountability

Integrated services sometimes 'fail' because there is lack of clarity regarding roles and responsibilities of practitioners, managers and leaders (Maslin-Prothero and Bennion, 2010). Before the service commenced, it was therefore imperative that governance arrangements were clearly established. Governance is the set of activities that ensures services function effectively and are accountable to the people they serve (Edwards and Miller, 2003). These include setting the purpose and vision, developing the strategy, delegating and implementing the

service while promoting excellence throughout. All these activities are underpinned by robust accountability to service users, practitioners and commissioners.

Clear lines of reporting and accountability were established (see Figure 1). As this was a safeguarding pilot funded solely by the NHS, the nurse was accountable to the associate director for children and families within Community Health Stockport and reported from a clinical perspective to the named nurse for child protection. This accountability would have only been for the duration of the pilot with the expectation, if the project continued, that the named nurse would take on this responsibility. On a daily operational basis the nurse reported to the social care team manager, who also managed social workers in the early intervention team.

This working arrangement was underpinned by memoranda of understanding that detailed what was expected from each agency. The working arrangement and performance of the project was monitored and reviewed every three months by the governors and managers of each agency.

Performance management

When the service was established, it was important that data were collected regarding the nurse's activity. Each intervention was described and given a code related to the activity. The codes ranged from 'assessments' and 'advocacy' to 'training' and 'supervision', and were inputted into a performance management tool and analysed for frequencies.

In order to illustrate the different outcomes that were achieved by the nurse, a number of case studies were reviewed and some have been included here (see Box 1). Evaluation feedback was also received from professionals through four focus groups of health visitors and school nurses. The groups included a team who worked in an area with high levels of safeguarding work and was conducted by managers using standardised questions.

Box 1. Two case studies

Case study A

Information was received from a head teacher expressing concern that a mother may be inappropriately medicating her daughter for a condition that had not been diagnosed. The nurse knew where information would be stored with regard to any diagnosis or medication and completed prompt welfare checks with the child's GP and mental health services to clarify if a diagnosis was in place.

Once it was confirmed that there was no diagnosis, an initial assessment was completed immediately. The nurse had access to social care records and discovered that the child was previously subject to a child protection plan in another local authority, with concerns about the inappropriate use of health services. The nurse supported the social worker when completing the initial assessment, questioned the mother about the medication and directly challenged her information. The case was transferred for a core assessment and consideration of initial child protection conference.

Case study B

Information was received regarding concerns that a mother presented at a sexual health clinic with her four-month old baby, stating that the baby had a bruise on her forehead caused during contact with the baby's father. The baby was subsequently reviewed by the paediatric consultant, who did not find a bruise or concerns of non-accidental injury. No further action was recommended.

Following consultation with health professionals including the health visitor, the nurse raised concerns regarding the baby's frequent attendance at hospital and the mother's inappropriate use of health services and unwillingness to engage with health professionals who challenged her concerns about the baby. The nurse was well positioned to piece together information from various sources.

The outcome was that an initial assessment was completed, which subsequently recommended a core assessment and child and family worker support. The mother and baby were more closely supported and multiprofessional meetings were put in place to meet the family's needs.

A children's services manager sent electronic questionnaires to social workers and completed questionnaires were returned to the associate director who led the evaluation. Due to the small number of social workers who worked with the nurse, the questions and responses were themed on communication, working relationship, nurse's knowledge, efficiency, effectiveness and outcomes.

Social worker perceptions

Social workers cited the nurse's education, skills and the specialist interpretive knowledge about health as being a particular strength. On a basic level, the nurse was utilised to clarify health abbreviations used by health professionals in referrals. For example, a referral was received about a two week-old baby that reported 'a 12% loss in weight'. The social workers sought clarity from the nurse as to why this was significant, especially as there were concerns about the parent's capacity to meet their newborn's basic needs.

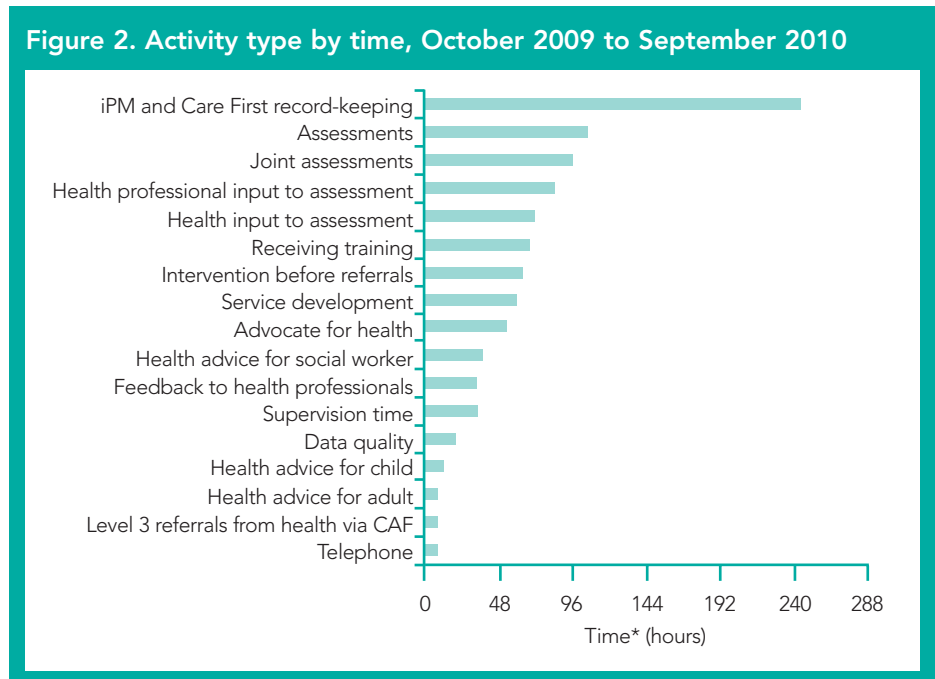
The nurse's knowledge about health was invaluable in decision making, initial assessments and home visits. A social worker stated that the nurse was able to inform them of the appropriate developmental stages for a young baby, including feeding and sleeping routines and in the way the father handled his daughter. They added that 'this was extremely valuable as it further evidenced the concerns from a health viewpoint'.

Feedback indicated that while undertaking joint social care visits, the nurse was also able to advise parents about health issues that were affecting children's health, education and wellbeing. Joint visits also provided the opportunity for the nurse to speak to young people, with parental consent, about health-related issues. It was noted that some families appeared less threatened by the presence of a health professional during an assessment.

Efficiency

A repeated theme from social workers was how the involvement of the nurse released time for them to escalate cases. One example of this was the nurse liaising directly with a consultant paediatrician about a possible fabricated illness case. The nurse was able to get through the medical 'gatekeepers' because of her authority, whereas it was noted that it would take time to establish a social worker's credibility.

It was interesting to note the complexity of health communication channels that the nurse was able to dissect on behalf of social workers. An example was given of a child



* Excludes annual leave and data quality issues

who had fractured one of their limbs and who was being seen by two consultants – orthopaedic and paediatric – a senior registrar and two senior allied health professionals. The nurse was able to interpret the information and feed back significant concerns to the social worker. This would have eventually happened, but the nurse was able to gather the information within two hours. For the social worker this would normally take over two days, and then they would have the issue of interpreting and giving meaning to the information.

Communication

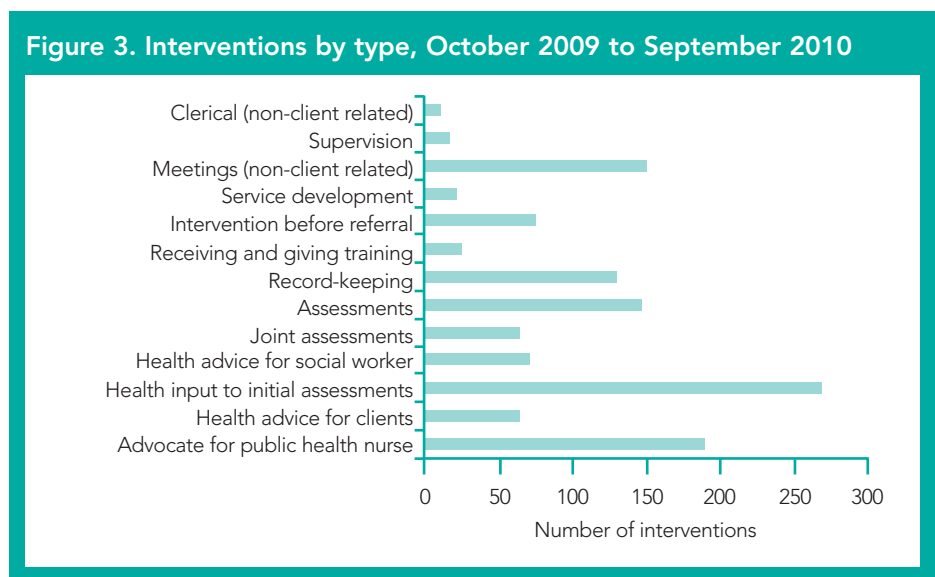
Social workers stated that at times they have found it difficult and intimidating to speak to consultants and GPs, and are often confused by the language and jargon used.

The nurse was thus a conduit for effective communication between the team and specialist health professionals. Equally, it was observed that by being placed within children's services and having a safeguarding title, health professionals felt confident about sharing information with the nurse.

The nurse attended the daily meetings within the early intervention team, so was well placed to pick up and act upon health-related concerns and referrals, either resolving the issue or escalating it to managers so that a decision could be made on the need for an initial assessment.

The effectiveness of the working relationship can be summed up by statements made by the social workers:

'The relationships between me and other health professionals around the local



authority have improved with [the nurse's] support and input.

'I really don't know how I would cope without [the nurse] now!'

Health visitor, school nurse perceptions Communication

All the health visitors knew the nurse and the process to contact her, and had a clear understanding of her role and the purpose of the pilot. Health visitors and school nurses acknowledged that the nurse was an aid to communication between health and children's services, improving access to critical information and interpreting health needs for social workers. As expected, the teams that had less safeguarding work had had less contact with the nurse, whereas the team with significant child protection work reported that they had contact with her two to three times per week on average.

All groups agreed that the role had supported them in their child protection work, leading to improved outcomes and a prompt service for children and families. For example, one health visitor said that the nurse had saved time, which meant that she has 'not had to make 20 telephone calls to find information and get support'. Practitioners felt it was a strength that the nurse was based within the same office as social workers, as she was able to liaise 'promptly and efficiently with social care'. All agreed that communication with social workers had improved since the role commenced and that social care interventions had occurred whereas previously this had not always been the case. As a health visitor stated:

'She breached the culture and language barrier which exists between the two services.'

School nurses reported that the nurse had communicated with GPs and fed back information to school nurses when appropriate.

Equally, the nurse challenged health practitioners' assumptions about the requirement for children's services intervention and provided advice on how to manage cases. This tended to be more readily accepted than if it was delivered by a social worker. On the other hand, the nurse helped to increase children's services attendance at team around the child meetings.

One of the key functions of the role was to be an advocate for health visitors and school nurses in response to their concerns regarding children and families. The dataset indicates that over the 12-month period, this amounted to approximately 50 hours of the nurse's time (see Figure 2). The data analysis shows that the nurse acted as an advocate on

180 occasions, an average of 15 times per month (see Figure 3). Over 14% of the nurse's activity was related to advocacy work.

Additional role development

When the nurse's role was developed, some elements were not foreseen. One was the training of health professionals and students about children's services systems and processes. The nurse facilitated visits to children's services for safeguarding practitioners, public health nurses and students. This generated an appreciation of the level of work that social workers have on a daily basis, which in turn has broken down some of the professional barriers between health and children's social services.

Information technology

A significant part of the nurse's time was spent on record-keeping using Care First (children's services system) or recording activity type on iPM (health system). Information technology (IT) was a major problem. The plan was to have one laptop for access to NHS and children's services systems. Due to the inability to make this happen, the nurse initially had to input health data from a nearby health centre with access to Care First from children's services. Despite extensive efforts, this issue was never resolved and the nurse therefore had to access two computers – one for health and another for children's services. This was an ineffective use of time and probably contributed to nearly a quarter (23.7%) of the clinical time being spent on electronic record-keeping and reporting. Of the total time available, data recording accounted for nearly one-fifth (17.5%).

The level and complexity of contact made with health professionals by the nurse was reflected in recordings undertaken of all telephone contacts with health professionals. Between January and August 2010, there were 566 telephone contacts with health professionals, involving information gathering for assessment and feedback to professionals. Of these calls, 40% were with health visitors and school nurses, and 13% with medical staff such as GPs and consultants.

Discussion

It has long been acknowledged that health visitors and school nurses have a vital role in protecting children from harm (Laming, 2009; DCSE, 2010). Nevertheless, they cannot do this in isolation, and when progressive needs are identified and additional services are required, then this has to be acknowledged by children's services. Unfortunately in Stockport, health practitioners' perception

was that their identification of progressive needs within families was often disregarded by children's services. At the same time, children's services articulated the need for health advice, information and support when undertaking initial assessments. A specialist community practitioner (the nurse) was therefore appointed to act as an advocate for health visitors and school nurses and support social workers undertaking initial assessments.

Overall, the nurse integrated extremely well into the early intervention team. This occurred because of a number of factors and can be used as principles for the establishment of integrated working. The integration was supported by a robust governance framework and agreement, which clarified and detailed roles and responsibilities as well as accountabilities. The expressed need by frontline practitioners for improved communication and information generated a climate of acceptance of the role; health practitioners were informed about the role and how it was to support their work prior to the nurse's commencement.

The nurse demonstrated a high level of professionalism and confidence in working across health and children's services. As a health professional, the role was fully accepted across the health economy and the nurse was able to gain direct access to medical professionals. Among the strengths identified from the focus groups and questionnaire is communication between health practitioners and children's services. The nurse acted as a conduit between frontline practitioners and children's services, and often translated health issues for social workers and vice versa. The nurse was more efficient than social workers in relation to navigating health systems and was able to gather information more proficiently.

It can be argued that the only effective form of integrated working is when staff and services report to one manager from a different agency (Maslin-Prothero and Bennion, 2010). The nurse was established on this principle – even though there was a health professional supervisor, the nurse had one children's services manager. The issue of role dilution (Whiting et al, 2008) was minimised due to the robust governance framework that was implemented.

One of the significant weaknesses of the approach was the failure to create an integrated IT system that supported this working. Despite extensive efforts from health and children's services managers, there are some bureaucratic barriers that can prevent true integrated working.

The pilot was created with goodwill and full support in principle from children's services and health, and the financial backing came entirely from the NHS. The pilot was to support health and children's services, and the data showed that – after data inputting and meetings – the nurse spent a major part of her time on assessments that contributed to children's services targets. The nurse achieved the objectives that were set out for the role, but despite proving successful the pilot came to an end due to lack of mainstream funding. Nevertheless, the pilot has set out that the role is beneficial for both agencies in their work to protect children. In the future, with effective joint commissioning there is a model that works, is appropriate and acceptable, and which creates positive outcomes for children and families.

Conclusion

The early intervention safeguarding nurse's role was to support social workers undertaking initial assessments, and health visitors and school nurses in their child protection role where there were perceived barriers to referrals to social care. The evaluation has shown that this was achieved. Improved communication between medical professionals and children's services, released time for social workers and increased professional tolerance between health and children's services were added benefits. The evaluation has shown that if we want to work in a truly integrated fashion in integrated teams, then a unified IT solution needs to be in place. Without this, many of the efficiencies of integrated working will not be realised.

This pilot has demonstrated that real integrated working can work for children and families when:

KEY POINTS

- Effective joint working between professionals and agencies is necessary in order to protect children from significant harm
- A pilot with a clear governance and accountability framework was created to integrate a health visitor within a children's services early intervention team
- The pilot identified positive outcomes for both professionals and families relating largely to improved communication processes
- Barriers identified include a lack of integrated IT systems to facilitate joint working
- When piloting integrated working, evaluation should be factored in to demonstrate to service users, providers and commissioners the value of such projects

- An integrated service is requested by frontline practitioners (ie an organic need is identified)
- Organisations appoint on attitude as well as skill, knowledge and experience
- There is a clear governance and accountability framework in place.

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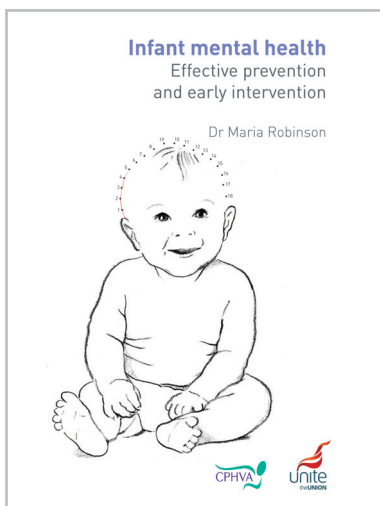
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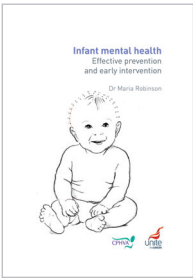
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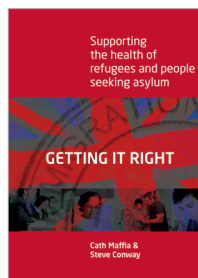
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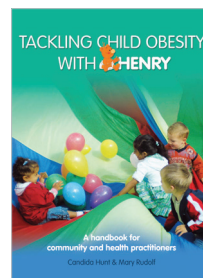
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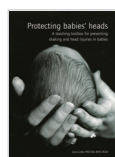
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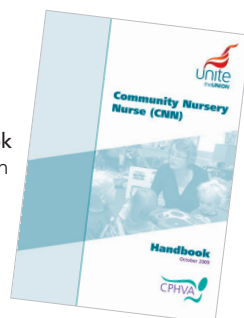
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