

Supporting the 'Multi' in Multi-agency working.

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The recently published national review¹ into the tragic deaths of Star Hobson and Arthur Labinjo-Hughes identified serious failings in multi-agency child protection working and recommended the establishment of Multi-Agency Child Protection Units (MACPU). The review also calls for the development of evidence based National Standards on what works when supporting children and families in multi-agency child safeguarding and advises that these are co-developed with input from relevant partner agencies. The recognition that there is a need to improve multi-agency working, and to create the knowledge and leadership needed to support that, is both timely and welcome.

Multi-agency working is the cornerstone of effective child safeguarding. This is embodied throughout safeguarding processes, from a policy and strategic level where safeguarding partnerships hold oversight of child safeguarding planning to the front-line delivery of safeguarding care². It seeks to bring together professional perspectives and knowledge from across the different facets of families' lives and interfaces with services, to provide a nuanced contextual understanding of the child within their family and social circumstances.

Multi-agency working can be complex; while the agencies and individuals involved typically share aims and goals about the safeguarding process, each has their own guidelines, practices, and processes. This is further complicated by the different structures of different agencies³. Some are considered or treated as a 'single entity' under an umbrella heading, for example 'education' or 'health' and this may obscure significant differences and layers of complexity within their structures and teams. For example, 'education' for one family could include several schools or pre-school settings which each function as discrete relatively autonomous units. 'Health' can include health visiting, midwifery, primary and secondary care – all of whom may be bound by different work protocols, professional guidance and/or boundaries.

This makes multi-agency collaboration complicated and difficult³. We know from child safeguarding practice reviews that the gaps in multi-agency processes are implicated in failings of child safeguarding processes, sometimes with devastating impacts¹. Bridging these gaps requires understanding how and when these gaps arise or are maintained.

While there are many commonalities between how agencies approach safeguarding, there are also differences in processes and a lack of a shared understanding of these can hinder cross agency and genuinely multi-professional working⁴. Simply reiterating the need for inter-agency working without understanding and addressing points of concern and divergence is unlikely to resolve all potential difficulties. Differences in professional 'culture' have been identified as contributory factors for differences in safeguarding practice⁵. We contend that a deeper understanding of safeguarding practices and how these look and feel on the front-line of multi-agency encounters is needed to mitigate against points of tension which hinder multi-agency working.

Information sharing is a powerful exemplar of how tensions between understanding and practice play out between agencies^{5,6}. Information sharing is at the heart of multi-agency working in safeguarding and it is frequently cited as a contributory factor when things go wrong^{1,7}. Information

sharing in practice is not always a straightforward process, even within a single agency⁷. Take for example 'health', where all medical practitioners are bound within the supportive framework of GMC guidance⁸. Here we see that there can still be differences in information sharing experience and challenges. Primary care often holds the records for many family members. This is a strength of primary care's contributions to safeguarding but can complicate processes of communication about what information needs to be shared and when or whether consent is needed. If there is immediate concern of significant harm, then this is relatively straightforward. However, situations are frequently more nuanced, requiring a shared understanding of processes and interpretations of consent. When a social worker asks the family for consent to approach general practice, what does that mean for the GP? As data guardians who know what is in the record, GPs may feel obliged to establish consent (unless consent is not needed) and this process can be uncertain. This can be especially complex when navigating decisions about whether and what they are allowed to share relating directly to the child but also about the wider family network implicated in a social worker's request.

Knowing how and what to document about what has been shared adds another layer of complexity⁹⁻¹¹, as does negotiating dissent or dealing with concern from family members. Information sharing for safeguarding can be complex and can feel relatively unsupported. Shared processes need to be about more than simply shared words or vocabulary³. We also need a shared understanding of what records comprise, of terminology and vocabulary and of how words and information are used and operationalised within different agencies.

These are timely and crucial issues to consider and explore in the context of proposed open access by default to general practice records later this year, including documents and free-text consultations¹². The initial proposed launch date for this was delayed because of concerns about safeguarding¹³, but there is now a proposed roll out date for 1.11.2022¹². We believe that this could have profound impacts on both the actual and perceived sanctity of health records for safeguarding because of concerns including the safety and visibility of third-party information, and concerns for clinicians about writing down personal observations within the medical record. Personal observations often contribute crucial information for safeguarding, but in our experience, clinicians worry that these may be construed as judgemental or cause conflict or schisms in their relationships with patients. Harming these relationships (and the trust within them) is also arguably harmful for ongoing safeguarding care.

In our experience, there are few opportunities for multi-professional learning, or inter-agency peer support and education. Education is sometimes delivered didactically from one agency to another, including in multi-agency groups, but that is not necessarily the same as an opportunity for reciprocal learning and reflection. We suggest cross-agency support for multi-agency working could include multi-agency mentoring, shared learning sessions, and multi-agency peer support.

A silver lining of the rapid responses to the pandemic was that moving multi-agency meetings online facilitated GPs attendance, a valuable and valued contribution to multi-agency safeguarding, noted by both social workers and GPs in research conducted independently in parallel, including by the authors of this piece¹³⁻¹⁵. This should be recognised and nurtured, but we can learn more about online multi-agency working, including how to ensure safety and develop trust and rapport. Only by reflecting critically and together can we do this. Relationship building is at the heart of multi-agency working, and sharing stories and findings can be part of this. When research is primarily conducted and shared within single agency professional meetings and publications, opportunities to do this may be missed⁴.

We wholeheartedly support the recent review's call for guidance that makes sense to each individual agency¹ – both as they work in parallel and as they intersect and collaborate. We would like support for navigating the evolving interface of multi-agency working to be co-produced with front-line safeguarding workers and responds to real-world dilemmas and uncertainties, and which acknowledges rather than dismissing them.

We will develop multi-agency working by accounting for different cultures and working practices of individual agencies and recognising points of divergence as well as areas of cohesion. We need to understand and consider what processes and structural factors underpin potential challenges or barriers. We need to work collaboratively and collectively understand how to enhance the capacity and capabilities of multi-agency safeguarding teams, from frontline practice to strategic policy. Sharing learning, practice, and research between agencies should form part of this process.

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