ORIGINAL ARTICLE

Factors Influencing Clinicians', Health Visitors' and Social Workers' Professional Judgements, Decision-Making and Multidisciplinary Collaboration When Safeguarding Children with Burn Injuries: A Qualitative Study

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Abstract

Burns are a common injury to young children, sometimes related to neglect or physical abuse. Emergency department (ED) clinicians, health visitors and social workers must work collaboratively when safeguarding children with burns; however, little is known about the factors influencing their professional judgements, decision-making and multidisciplinary collaboration. Objective was to explore factors affecting ED clinicians', health visitors' and social workers' professional judgements and decision-making when children present to the ED with burns, and experiences of multidisciplinary collaboration, to identify areas for improvement. This was a qualitative semi-structured interview study using purposive and snowball sampling to recruit participants. Data were analysed using 'codebook' thematic analysis. Four themes were identified: 'perceived roles and responsibilities when safeguarding children with burn injuries', 'factors influencing judgment of risk and decision-making', 'information sharing' and 'barriers and facilitators to successful multidisciplinary collaboration'. There is limited understanding between the groups about each other's roles. Each agency is dependent on one another to understand the full picture; however, information sharing is lacking in detail and context and hindered by organisational and resource constraints. Formal opportunities for multiagency team working such as strategy meetings can be facilitators of more successful collaborations. Professionals may benefit from multiagency training to improve understanding of one another's roles. Greater detail and context are needed when notifying health visitors of burn injuries in children or making a referral to children's services.

Key Practitioner Messages

- Emergency department clinicians, social workers and health visitors need a better understanding of each other's roles and responsibilities in safeguarding children with burn injuries.
- To make decisions in individual cases, professionals need to be aware of the risk factors that are known to each agency.
- Social workers and health visitors may benefit from further training in the clinical features of abusive and neglectful burns.

- Emergency department clinicians could improve the level of detail and context that they provide when notifying a health visitor about burn injuries in young children or making a child protection referral to a social worker.
- All professionals could improve information sharing by providing regular feedback on individual cases and attending multidisciplinary meetings.

INTRODUCTION

Burns are common in early childhood. Around 40,000 children attend emergency departments (EDs) in the United Kingdom annually with burns, and the majority are aged less than 5 years (Davies et al., 2020). Maltreatment is suspected in an estimated 9–25 per cent of cases (Bousema et al., 2016; Chester et al., 2006; Collier et al., 2017; Hayek et al., 2009; Hight et al., 1979; Wibbenmeyer et al., 2014). Children less than 3 years old admitted to hospital with burns are more likely than matched controls to suffer from abuse or neglect, to be a child 'in need' or to be hospitalised with an unrelated condition, by their sixth birthday (Hutchings et al., 2010; James-Ellison et al., 2009). Burns caused by neglect, including lack of supervision, are more common than burns arising from physical abuse (Chester et al., 2006; Loos et al., 2021). Distinguishing between negligent, abusive and accidental paediatric burns can be challenging, particularly as ED clinicians operate in a high-pressure environment with variable levels of paediatric and safeguarding expertise. There is no gold-standard diagnostic test or clear-cut guidelines to identify burns caused by maltreatment, and determining the mechanism of injury is difficult because the history provided by the caregiver may be fabricated or misleading. Yet this distinction is crucial for ensuring appropriate interventions. If maltreatment is not identified, children may be returned to an abusive environment and reinjured; however, an incorrect diagnosis of maltreatment may see parents falsely accused and children unnecessarily removed from their families.

In the United Kingdom, the National Health Service (NHS) is responsible for health care, while local government is responsible for social care, including children's social care (CSC) services (see Appendix S1 for further detail about CSC services). All children less than 5 years old in the United Kingdom have a named health visitor (HV). An HV is a qualified and registered nurse or midwife who has undertaken additional training to become a specialist community public health nurse. The role of an HV is to support and promote child and family health and wellbeing; safeguard the child; and provide advice and support to parents with regard to accident prevention. In many hospitals, the child's HV is notified of any ED attendance with an injury, and the HV has a responsibility to follow up with the family. Both ED clinicians and HVs have a further responsibility to refer children with suspected maltreatment to CSC, although it is important to note that reporting in the United Kingdom is not mandatory. Child safeguarding guidance from across the four nations states that professionals from these three disciplines are required to work collaboratively and share information, as 'no single practitioner has a full picture of a child's needs and circumstances' (Department for Education, 2018, p. 11; Department of Health, 2017; Scottish Government, 2021; Welsh Government, 2019). Professionals are expected to understand their role and that of other practitioners in safeguarding children (Department for Education, 2018). While ED clinicians and HVs are normally employed by the NHS, social workers (SWs) are usually employed by local authorities.

The identification of child maltreatment and the quality and effectiveness of multidisciplinary collaboration between health and social care have long been topics of interest (e.g. Ambrose-Miller & Ashcroft, 2016; Cowley et al., 2018; Fox & Dingwall, 1985; Whiting et al., 2008); however, most studies have explored the experience of multidisciplinary collaboration from the perspective of SWs. The health visiting role in safeguarding children has received little attention compared to other areas of health visiting, and few studies have investigated HVs' perceptions of multidisciplinary collaboration (Peckover & Appleton, 2019). Those that have found that HVs felt other professions lacked an understanding of their role and that conflicting values, complexity of cases and professional hierarchies were barriers to interprofessional collaboration (Machin et al., 2012; Machin & Pearson, 2013; Taylor et al., 2017; Whiting et al., 2008). Studies exploring multidisciplinary collaboration in child protection among other professional groups and again outside of the context of burn injuries have identified further barriers to successful multidisciplinary working. These include a lack of supportive organisational structures; inadequate resources; unrealistic expectations; professional knowledge boundaries; poor communication; and a need for clarification of roles and responsibilities, among others (Darlington et al., 2005; Frost et al., 2005; Kistin et al., 2010), Facilitators to successful multidisciplinary collaboration include trust and communication; a shared identity and purpose; feedback and evaluation; professional autonomy; and a supportive culture (Bronstein, 2003; Lalayants, 2013).

FACTORS INFLUENCING CLINICIANS', HEALTH VISITORS' AND SOCIAL WORKERS' PROFESSIONAL JUDGEMENTS, DECISION-MAKING AND MULTIDISCIPLINARY COLLABORATION WHEN SAFEGUARDING CHILDREN WITH BURN INJURIES: A QUALITATIVE STUDY

Association of Child Protection Professionals

3 of 18

In addition, many studies have examined the challenges associated with decision-making in child protection and the factors influencing professionals' judgements and decisions in this field (Cowley et al., 2018; Hood et al., 2022; Kirkman & Melrose, 2014; Lauritzen et al., 2018; Munro, 2019; Munro, 2020; Whittaker, 2018). Child protection work entails significant statutory duties and responsibilities, involves high workloads and competing demands, and can be emotionally distressing (Cowley et al., 2018; Hood et al., 2022; Munro, 2020). Furthermore, professionals often must make crucial judgements under conditions of risk and uncertainty and in exigent circumstances, and a range of heuristics and biases can influence their ability to make objective judgements (Kirkman & Melrose, 2014; Munro, 2019; Whittaker, 2018). In the United Kingdom, the issue of professional judgement gained traction following the Munro Review of Child Protection, which examined social work practice through a socio-technical systems lens (Munro, 2011). Munro argued that the formulation of responses within an excessively procedural, bureaucratic and technical-rational decision-making framework was restricting and undermining professional expertise and emphasised the importance of the interaction between organisational and individual factors in facilitating effective decision-making (Munro, 2011). Similarly, other studies have consistently found that there are four factors that are considered fundamental for child protection decision-making: case characteristics, caseworker characteristics, organisational characteristics and external factors (Lauritzen et al., 2018).

However, little is known about the factors influencing practitioners' professional judgements, decision-making and multidisciplinary collaboration in the context of paediatric burn injuries. We aimed to explore the factors affecting ED clinicians', HVs' and SWs' professional judgements and decision-making when a child presents to the ED with a burn, as well as their experiences of information sharing and multidisciplinary collaboration to identify potential areas for improvement. Our approach is aligned with the definition of multidisciplinary collaboration outlined by NHS England (2014): 'Multidisciplinary and multiagency working involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social care or voluntary and private sector providers to redefine, re-scope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient need(s)' (p. 12). In addition, we have adopted the definition of professional judgement and decision-making provided by Taylor (2017), who states that a professional judgement is 'when a professional considers the evidence about a client or family situation in the light of professional knowledge to reach a conclusion or recommendation' and that a decision is 'the selection of a course of action as a result of a deliberate process by one or more people. Sometimes judgments and decisions merge into each other; in other situations they are more distinct. A decision may be made by one person, or it may be the result of a decision process involving a number of people' (p. 21).

METHODS

A qualitative semi-structured interview study was conducted as part of a wider research programme evaluating the impact of the Burns Risk Assessment of Neglect and Maltreatment in Children Tool (BuRN-Tool). The derivation and validation of the BuRN-Tool has been described previously (Kemp et al., 2018). Ethical approval was granted by the NHS Health Research Authority, Wales Research Ethics Committee 3 (reference 15/WA/0259). This study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007); Appendix S2.

Participant recruitment

Purposive and snowball sampling were used to recruit ED clinicians, SWs and HVs from England and Wales. An email and information sheet were cascaded to managers of 11 HV and CSC teams, and to ED consultants at two paediatric EDs, who were asked to suggest suitable participants with different levels of safeguarding experience and seniority (Figure 1). ED clinicians included trainees, nurses and consultants; HVs included generic HVs, specialist Flying Start HVs who work with families with higher levels of need and managers; SWs included those working in referral/assessment teams, frontline SWs, managers and consultants.

Sample size considerations

Sample size was guided by 'information power', whereby the more information the sample holds, the fewer participants are required (Malterud et al., 2016). For pragmatic reasons, sampling, data collection and analysis were undertaken in distinct stages; thus, it was not possible to determine when 'thematic saturation' was achieved (Baker & Edwards, 2012; Varpio et al., 2017). The concept of information power posits that a study needs fewer participants if the aim is narrow;
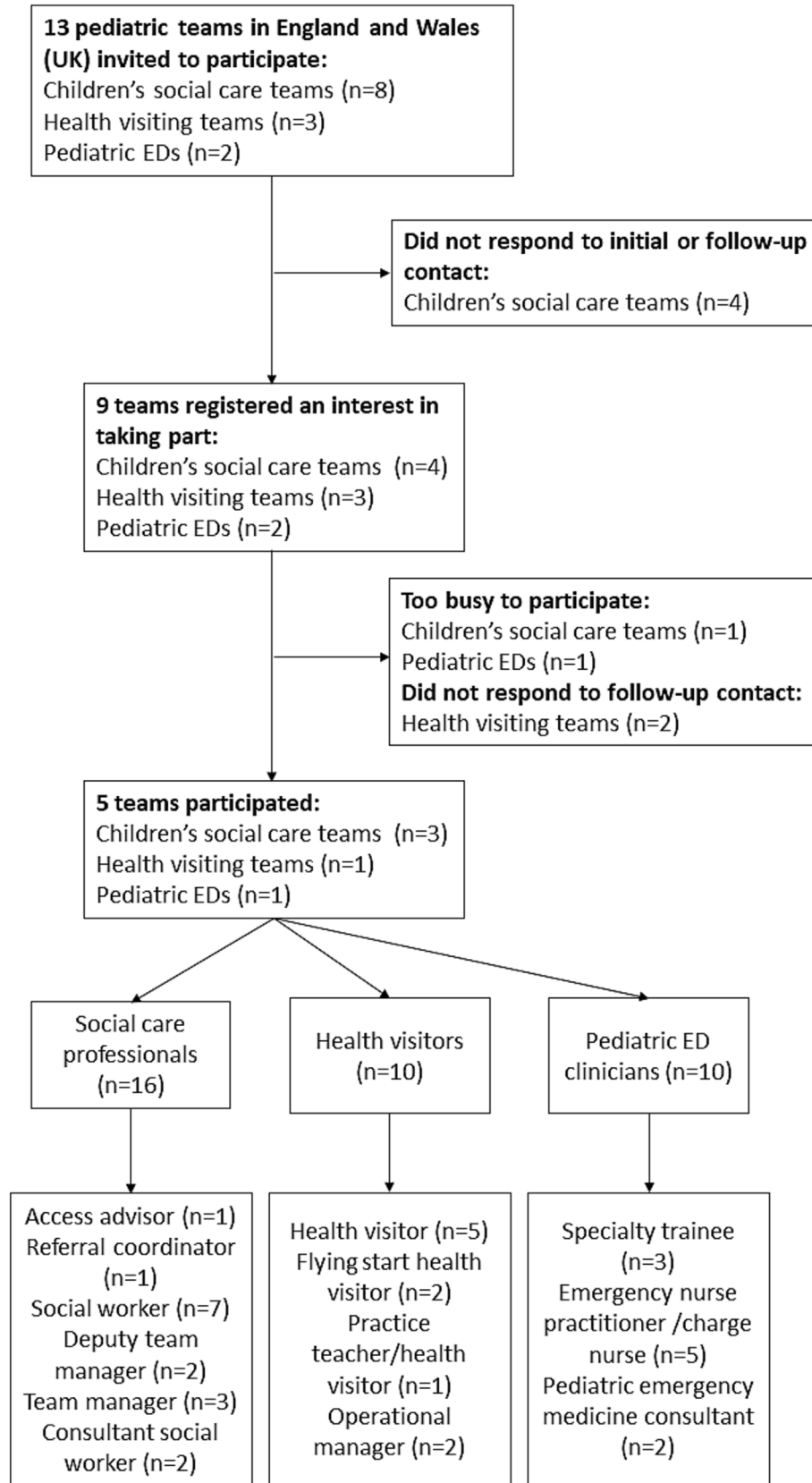
F I G U R E 1   Participant flowchart.

FACTORS INFLUENCING CLINICIANS', HEALTH VISITORS' AND SOCIAL WORKERS' PROFESSIONAL JUDGEMENTS, DECISION-MAKING AND MULTIDISCIPLINARY COLLABORATION WHEN SAFEGUARDING CHILDREN WITH BURN INJURIES: A QUALITATIVE STUDY

Association of Child Protection Professionals

5 of 18

if participants hold characteristics that are specific for the study aim; if the study is informed by established theory; if the interview dialogue is strong; and if the analysis does not require cross-case comparisons. In the current study, the aim was neither especially broad nor narrow; the sampling strategy ensured that participants with characteristics specific to the study aim were recruited; the study was not theoretically founded; the interviewer was experienced and able to establish a strong dialogue with participants; and cross-case analysis (examining similarities and differences across interviews) was required to compare the experiences of different professional groups (Malterud et al., 2016). In addition, a previous study conducted by the lead researcher on a similar topic produced rich data from upwards of eight interviews (Cowley et al., 2018). Therefore, a minimum sample size of 10 participants from each professional group was considered appropriate.

Interview schedule development

We chose to conduct in-depth, semi-structured interviews in order to build a rapport with participants and gain a rich understanding of their attitudes and experiences (DeJonckheere & Vaughn, 2019). The interview schedule was developed by LEC and CVB, reviewed by a SW (DW) and consultant paediatrician (AMK) and revised accordingly (Appendix S3). Questions were derived from the scientific literature on decision-making and multidisciplinary collaboration in safeguarding and the identification of paediatric burns caused by abuse or neglect. The schedule was piloted internally and amended as necessary. Interviews explored participants' usual practice and decision-making when safeguarding children with burn injuries and their experiences of multidisciplinary working. The schedule comprised core open-ended questions, prompts, probing and clarifying questions and allowed exploration of additional topic areas that might be raised by participants. Early interview responses influenced questions asked in later interviews; the schedule was updated as data collection progressed and new topic areas were raised.

Data collection

Interviews were conducted by LEC, a post-doctoral researcher in population medicine, trained in qualitative research methods in the field of decision-making in the context of suspected child maltreatment. No relationship was established between the interviewer and participants prior to the study. Participants were informed that LEC was part of a team undertaking research on child maltreatment; the study rationale was outlined in the information sheet. Informed consent included permission for audio recording and verbatim transcription and for the use of direct anonymised quotations in any publications. Interviews were guided by participants; they lasted approximately 45 minutes and took place at the participants' workplace between April and May 2019. CVB was present at five initial interviews with SWs for support and guidance and asked some additional questions based on participants' responses. No repeat interviews were conducted. In the interests of reflexivity and to minimise bias in data collection, LEC considered how her knowledge, experience and status might influence the interviews, the interpretation of the findings or the power balance between the interviewer and participants. LEC made field notes immediately after each interview to record critical reflections about participants' responses. Participants were not asked to comment on the transcripts.

Data analysis

Data were analysed using a 'codebook' approach to thematic analysis (Braun et al., 2018; Braun & Clarke, 2019). Thematic analysis is a method for identifying and describing patterns across data (Braun & Clarke, 2006). 'Codebook' approaches recommend a structured coding framework for developing and documenting the analysis yet remain embedded within a broadly qualitative paradigm (Braun & Clarke, 2019; Braun & Clarke, 2020). Such approaches are ideally suited to investigating professionals' experiences and perspectives, evaluating organisational processes and generating results that are actionable by practitioners (Braun & Clarke, 2014; Braun & Clarke, 2020). Analysis was an iterative process and involved grouping codes into categories and further arranging categories under overarching themes. This involved six phases: (1) data familiarisation and writing familiarisation notes; (2) systematic data coding; (3) generating initial themes from coded and collated data; (4) developing and reviewing themes; (5) refining, defining and naming themes; and (6) writing the report. A general inductive approach enabled the results to be guided by both the aims and objectives of the research and the raw data (Bryman & Burgess, 1994; Dey, 1993).

Data were analysed by LEC, who developed the final coding framework (Appendix S4). Three other authors (DN, HQS and AMK) analysed subsets of the data and the analysts shared their findings to ensure concepts within the data were not overlooked, and gain a richer understanding from multiple perspectives, rather than to measure coding reliability or seek consensus (Braun & Clarke, 2019). Transcripts were imported into NVivo 12 (QSR International Pty

Ltd., 2018). Participants were not asked to provide feedback on the study findings. Quotations from clinicians (C), HVs and SWs are provided as examples and evidence of the themes and categories that were generated. Quotations were tabulated by theme, for ease of reference and to ensure that the narrative and flow of the text was not interrupted. Within quotations, square brackets represent text inserted for clarification. Word repetitions and irrelevant sections were removed and denoted by '…'

RESULTS

Participant demographics and response rates are shown in Table 1 and Figure 1. Participants are broadly representative of the UK workforce with respect to gender and ethnicity (most UK SWs and HVs are white females). Four principal themes were identified: Theme 1 'professionals' perceived roles and responsibilities when safeguarding children with burn injuries' (Table 2), Theme 2 'factors influencing judgement of risk and decision-making' (Table 3), Theme 3 'information sharing between professional groups' (Table 4) and Theme 4 'barriers and facilitators to successful multidisciplinary collaboration' (Table 5). Categories and their definitions are detailed in the coding framework (Appendix S4).

Theme 1: Professionals' perceived roles and responsibilities when safeguarding children with burn injuries

Professionals' perceptions about their own roles and responsibilities

ED clinicians and HVs said that part of their role when assessing children with burn injuries is to make a professional judgement regarding the likelihood that abuse or neglect has occurred, and to identify potential safeguarding concerns

T A B L E 1 Demographics of social workers, health visitors and emergency department clinicians participating in a qualitative study of decision-making in paediatric burn injury cases.

	SWs (N = 16)		HVs (N = 10)		ED clinicians (N = 10)	
	n	*%*	*n*	*%*	*n*	*%*
Gender						
Female	15	94	10	100	5	50
Male	1	6	0	0	5	50
Age group						
25–34	4	25	1	10	3	30
35–44	8	50	4	40	6	60
45–54	4	25	4	40	1	10
55–64	0	0	1	10	0	0
Ethnicity						
White British	16	100	10	100	9	90
White and Black Caribbean	0	0	0	0	1	10
Years in CP						
<5	6	38	0	0	1	10
5–9	5	31	3	30	2	20
10–20	5	31	5	50	6	60
>20	0	0	2	20	1	10
CP training						
Undergraduate	5	31	0	0	1	10
Level 1 or 2	2	13	0	0	1	10
Level 3 or above	9	56	10	100	8	80
Paediatric burns training						
Yes	2	12	1	10	8	80
No	14	88	9	90	2	20

Abbreviations: CP, child protection; ED, emergency department; HV, health visitor; SW, social worker.

FACTORS INFLUENCING CLINICIANS', HEALTH VISITORS' AND SOCIAL WORKERS' PROFESSIONAL JUDGEMENTS, DECISION-MAKING AND MULTIDISCIPLINARY COLLABORATION WHEN SAFEGUARDING CHILDREN WITH BURN INJURIES: A QUALITATIVE STUDY

Association of Child Protection Professionals

7 of 18

T A B L E 2 Participant quotations informing Theme 1: Professionals' perceived roles and responsibilities when safeguarding children with burn injuries.

Professionals' perceptions about their own roles and responsibilities

ED clinicians	'If it [the burn] does not really fit in with the story then you would make a judgment. It's not my job to investigate it. It's not my job or part of my job to establish whether it really fits in with what we are seeing and therefore I'd refer it on to the appropriate services.' C 6
Health visitors	'Our role is not to make the decision, it's to refer onto children's services to make a decision … we are more there as a signposting service, we are there for recognizing and acting on child protection concerns.' HV 1
Social workers	'The judgement is not just made by us. It would be made with other professionals … I guess we do in some ways make some at the end about what we suspect has happened and I think that's from gathering the explanation of what's happened, and whether that's plausible, from other professionals.' SW 12 'Our decision is informed by what the paediatrician tells us. So if the paediatrician tells us it's a non-accidental injury it's down to us then and the police as to what our next steps are going to be. We cannot make our decision without the paediatricians giving us what they feel has happened because we are not experts in injuries and burns. We cannot make that decision ourselves. We're not medically trained. We rely on them to give us that information.' SW 13

Professionals' understanding of the roles and responsibilities of other disciplines

Health visitors	'There is always a demonstration of a lack of understanding of our role, by the standard comments we get on a form that they [ED] send back to us, basically "please reinforce safety advice", when we do that at every single visit that we do with them … the place to reinforce things is when this happened. So I think we can work better in partnership with each other, between us and the ED with a better understanding of each other's roles.' HV 1 'I've had very poor experiences with social workers, and I think a lot of it comes down to possibly a lack of understanding of our role. I do not think they realise the complexities of our role and the fact that we are so heavily involved in safeguarding.' HV 1 'Sometimes the ED will send us reports and say this child has come in with an injury, please go out and visit the family for safety information. I do not feel that I need to be dictated to and told to do that. They could be discussing safety with the family in the hospital setting.' HV 3 'Social workers have tried to use us to monitor the family in certain circumstances to which we have said "no that's not our role". If they have got concerns, they need to go out there. We need to be jointly working together.' HV 4
Social workers	'We do have situations where as soon as a social worker's involved, health visitors back away and that's absolutely not ok, you are going into that house, you are seeing things, you are a whole other pair of eyes that can add into our assessment, they need to be able to monitor things and make good decisions about whether things need to come back into us.' SW 3 'Sometimes families work with health visitors whereas they will not work with social workers so sometimes in that sense it's good to keep that rapport built between the health visitor and the parents, rather than CSC knock on the door and it all blows up, so sometimes it's about using people to your advantage in terms of working with families. There's a lot of low-level stuff that health visitors could just monitor for us.' SW 6 'I think they [ED] expect us to just run in and save the day if I'm honest.' SW 16 'I think that they [ED] expect us to go out and visit every family or investigate every family and maybe consideration has not been given to the impact on the family of doing that because we cannot unless we have got significant concerns.' SW 11 'A lot of the referrals [from ED] ask for an assessment, they ask you to see a child. I think they assume we will always go out; I think they are probably not always aware that it's not necessarily just the CSC team, there's the domestic violence service. We work with the police, with early help family support workers, schools, health visitors, so it's not always us that might need to do that work.' SW 8

Professionals' expectations of other disciplines

ED clinicians	'I would expect the health visitor to do a home visit and to check the house and check the situation. I would expect them to do a welfare check on them.' C 1 'I would expect them to act, especially if it's lack of supervision, neglect, a cup of tea lying around on the floor with a crawling baby, I would expect them to follow that up. A lot of the evidence will tell you that parents do not listen or do not take in what we tell them in the Emergency Department. I'll always say "you should be putting that cup of tea away", but they do not always take that on board so absolutely I would expect health visitors to take action.' C 7 'The health visitors should know their families to know who to go out and do a home visit for, I do not know that family well enough to make that judgement.' C 9 'I expect social workers to contact or further investigate the family and the children and see if there's any other issues that we are not aware of and go out and investigate, go out to the scene and meet the family.' C 8 'It depends if the family are already known [to children's services]. It does not automatically mean that the social worker is going to have to go out and see them. It depends on individual circumstances.' C 9
Health visitors	'I would expect that they [ED] have discussed safety with the family there and then, as they are about to be discharged. Strike while the iron is hot, if you like. I understand though, their point of view is that sometimes parents are too distressed to take in the information.' HV 3 'I would have expected the ED to have put a referral in if they have got concerns straightaway. I would have already expected whoever had seen them to have referred on to CSC and informed the family why they were doing that because a lot of the time it seems that there might be a mild concern, but they do not want to put the referral in themselves because they do not want to face that conversation.' HV 6

(Continues)

TABLE 2 (Continued)

	'I think it's very difficult especially if they have just been seen in the ED. They are only just seeing that family for a snapshot of time, so they cannot telephone every health visitor for every child that they see because that's just totally impractical.' HV 7
Social workers	'I'd expect that they [ED] would be taking on responsibility for making appropriate referrals for information sharing, whether it's CSC, other health professionals as well, taking responsibility for ensuring that the systems are updated with information, but also that parents know what is happening.' SW 8 'I'd expect them [ED] to give me background information about the child's hospital attendances. If there is a discussion about a non-accidental injury, the relationship between the parents and the child, and obviously their opinion on whether they felt it was accidental or non-accidental and have they spoken to the parents to gain information about the incident?' SW 14

TABLE 3 Participant quotations informing Theme 2: factors influencing judgement of risk and decision-making.

Gathering information

ED clinicians	'It's about weighing up, gathering all the evidence, all of the background and the historical things, what's going on in the family at the time and putting all that together to build a picture.' C 7 'I take the history of the burn, work out the mechanism, the age of the child, developmental stage of the child, mechanism of the injury, what the agents were, how the agents were in contact with the skin, was it spill or pull-down, then I check safeguarding issues: who was in the vicinity, what first aid was applied … you are looking for anything that is not in-keeping with the history, whether the child has any other injuries, and then I check PARIS [the digital records system maintained by health visitors] and consider safeguarding issues, or concerns around supervision.' C 3
Social workers	'The most important bit would be the information from the medical side, but then part of that if it's holistic would be observations, the parent's presentation, their reactions, their explanations, so it's just part of a puzzle.' SW 7 'I think the history is really crucial, the context and how many times they have presented, and then the opinion of the actual burn or injury, what is it, where is it, the parents' or carers' description of the cause, does that fit with what the health professionals are saying … then you would be wanting to know a bit more about the presentation, so how are the child and the parents when they are at the hospital setting … have they said something that might be a bit worrying, is their behaviour challenging or is it appropriate.' SW 6

Quality of information in the referral/notification

Health visitors	'We may not have as much information as we need to make an assessment, in which case I would have a very low threshold for going out and visiting that family.' HV 1 'Sometimes it does depend on the description and the detail of the history from the parents, whether we make a clinical judgement to go out and physically see the family.' HV 9

Social history and risk factors

Social workers	'We consider medical evidence but we also consider the family circumstances. We will speak to the family to seek the explanations and then we would consider whether or not that injury is plausible. If we come up with something that could potentially be a plausible explanation it's getting that expert verification. So we rely a lot on health professionals to help us along that road in respect of the actions we need to take following a burn injury to a child.' SW 16 'We've got some different questions probably more around the context, not necessarily what the injury or burn is, we have got to think of the context and the way it's happened and the risk after they leave that setting.' SW 8 'We look at risk factors around lack of supervision, have they been known to us previously, any issues around substance misuse which might indicate that this child wasn't supervised properly because parents were under the influence and unable to supervise them, any issues around domestic abuse which might then indicate to us that this child is not being monitored properly and that's how this injury has happened. Anything around mental health is going to be a risk factor.' SW 3

Knowledge of the family

Health visitors	'You make your decisions based on your knowledge of the family.' HV 2 'I think if you did not know the family then you would go out and see the family and to discuss. If you did know the family then I think sometimes you would probably do a telephone call if it was a family you did not have concerns about and there was an obvious mechanism for the injury.' HV 7

Knowledge of the clinical features of abusive or neglectful burn injuries

Health visitors	'We do have some training on it, but I would not profess to be an expert on it, and although we do need to have an awareness of it, you would rely on the paediatrician or the ED, or the experts to signal to you that they are concerned that this could be a non-accidental injury.' HV 2
Social workers	'You would think the greater the area [of the burn], the worse it is, but I do not know, the hospital might have a different view … it's definitely a weakness, I do not know much about burns at all.' SW 15 'I would definitely attend training on that to give me that bit of knowledge but I would probably still rely on the experts.' SW 11 'Burns [training] would be useful, I had not realised it was such a gap in my knowledge!' SW 7

FACTORS INFLUENCING CLINICIANS', HEALTH VISITORS' AND SOCIAL WORKERS' PROFESSIONAL JUDGEMENTS, DECISION-MAKING AND MULTIDISCIPLINARY COLLABORATION WHEN SAFEGUARDING CHILDREN WITH BURN INJURIES: A QUALITATIVE STUDY

Association of Child Protection Professionals

9 of 18

T A B L E 4   Participant quotations informing Theme 3: information sharing between disciplines.

The quality of information received from ED clinicians by HV and SW	
Health visitors	'So any children that go to the ED, we are notified electronically and we get a notification in the post as well. We do not always get them immediately … the ED will give us minimal information. It varies, usually with a burn or scald they would give more information, there would be a separate sheet, but not always.' HV 3 'When the notification comes electronically, it's very limited. There will not be much information at all, it will not say the child has done this and the story concurs with the injury, it will not have any detail on it at all.' HV 10
Social workers	'We can have one-liners or in-depth information, sometimes if they are not overly concerned you get one or two lines, if the hospital are concerned you get a lot of detail. But we cannot be sure that's why we have only got one or two lines, so we have to go back to them and say "we cannot make a decision on the information that you have given to us".' SW 2
Information that HV and SW require	
	'I think it's a question of putting enough flesh on the bones when they put in the referrals because quite commonly if a referral goes in they have not put how mum and dad interact with the child … they need to put the full picture not just a one liner and I think that's been critical before now. There has to be more information.' HV 10 'We need more of the story, more of the scenario, more of the "what happened".' HV 1
Social workers	'I think it's to do with the amount of context that's in the referral, which is what we crave, as much context as possible because that's how we make our judgments.' SW 1 'You need to put it into context and give us more details, are you worried, what's your opinion on the injury.' SW 2 'They're very good at not putting any contact details for parents on. Often they have not ticked whether they have even got consent. What we actually need is what we call informed consent, we have to get referrals sent over that say we have told the parents that we are doing this and they understand the reasons why.' SW 2 'A lot of the time we quite often go back and say but have you spoken to the parents, it does not meet the threshold for us making any decisions without consent.' SW 7
Organisational barriers to information sharing	
Health visitors	'I think communication is really poor. I think it would make life easier if everyone was using the same system. Certain people use PARIS [safeguarding database], certain people do not.' HV 6 'Often whoever deals with the child will then go off duty, it's difficult to phone up and find the person, the notes have often gone, and the information is not necessarily there.' HV 1 'It's difficult in our job because we are out visiting. You can play telephone tag for weeks without being able to get hold of people and then people work shifts as well so it's difficult from that point of view.' HV 5
Social workers	'It's quite frustrating that we are all on different IT systems and it's a lot of calls then back and forth and everybody's busy and you keep on missing each other.' SW 15
ED clinicians	'The problem is that we work 24/7 so we expect to have things at our service 24/7 when people work nine to five, so in those hours it tends to be very quick and a decision is made but out of hours then it's really difficult.' C 1
Suggestions for improvement	
ED clinicians	'We have invited children's services to our weekly meeting when we discuss thermal injuries but at the moment it has not been taken up. That could be a forum for us to discuss these cases.' C 3 'It would be nice to get feedback on what we have done or what we have asked to be done. Feedback about whether it's relevant or irrelevant or whether there's something else we could have done instead, that would be useful and may actually make services a little bit better or more productive.' C 5
Health visitors	'I appreciate the ED are very busy so they only use PARIS for the injuries they are concerned about, but they do not always know the family, whereas we do. So it would be useful if everything came via PARIS so you are not relying on a piece of paper that's going in the internal mail, which could take a while to get to you.' HV 2 'I think it should be done electronically because the ED have got access to PARIS, paper is old fashioned in this day and age, we should not be using paper referrals, why aren't we getting things done electronically?' HV 3
Social workers	'A standardised form would be great would it not?' SW 14
Referrals for information sharing vs. referrals for support/safeguarding	
ED clinicians	'It's the whole picture it's not just that one injury, you have that one more referral and you think right that's enough now I can escalate this. So sometimes that one more bit of information sharing can help.' C 9 'If they have already had involvement with children's services or they have current involvement, even if I had no real safeguarding concerns I would let them know just to say look this has happened, you need to know about it … it will build evidence, build a picture.' C 7
Health visitors	'The more information the better, because it just adds to the picture then, especially if we have had historical concerns or low level concerns that have been going on for a little while, and even if the ED have not made a referral to children's services, it may be a trigger for us.' HV 2 'I think the frustration for us it that you can refer to children's services and then the family just get a letter and nothing's going to be done about it, but if we have not done that referral then you have not proven that you have got concerns and you build an overall picture then.' HV 7
Social workers	'Sometimes a child has had a burn and there's no need for us to know. If the hospital are happy with the explanation that is given we do not need to know. So sometimes we do get referrals where we are just being told information.' SW 13

(Continues)

TABLE 4 (Continued)

'If we had multiple referrals in that never went anywhere, and then you have got your running log of a child that had injuries and has been admitted to hospital quite a lot then that's really helpful, it would be great to build that information but where do we stop that?' SW 6
'Other services think we are a logging service. I would not say it's proportionate for us to be able to log every single thing. If you can see on your system that this has happened a lot, I think that's when the onus needs to be on that person to raise their concerns then.' SW 8

TABLE 5 Participant quotations informing Theme 4: Barriers and facilitators to successful multidisciplinary collaboration.

Communication	
Health visitors	'When you work with a social worker that actually appreciates your role and will work with you, it works very well, but there will be some scenarios where that is not the most important child on their caseload, it's very hard to get hold of them, it's very hard to get feedback and feedback often determines what we do.' HV 1
	'The strategy meeting is so valuable, because everybody comes from a different angle, and usually as a health visitor we are very informative at those meetings, because we know the families, we have been to the home. We might know their previous children, we might know the family dynamics a bit more. Sometimes meetings may be cancelled, and you are not informed, but we are talking minor communication problems really. I think if there's a child protection concern, we work well together with other agencies.' HV 3
	'I've never really been in a situation where somebody has been reluctant to give their honest opinion or concerns about a child.' SW 4
	'I think MASH, the Safeguarding Hub, helps with communication, because all of those agencies are in that one place.' HV 2
Social workers	'I think sometimes there's been some really good working together and then sometimes not.' SW 7
	'The whole point of the strategy meeting is to get that overview from everyone's professional viewpoint so I know some bits about the medical side, but I do not know exactly what's what, that's why that's needed.' SW 4
	'Sometimes it's very difficult to get a clear opinion from the medical profession on whether it's accidental or non-accidental. They sit on the fence and that makes our job very difficult.' SW 14
	'I have been to child protection medicals where you cannot get a straight answer out of a paediatrician or they do not want to nail their colours to the mast and say yes it's accidental or yes it's non-accidental.' SW 2
ED clinicians	'I think communication with social workers is better now we have got the MASH Hubs.' C 7
Pressure on public services/caseloads	
ED clinicians	'Unfortunately we are in a climate where there is pressure on all public services and therefore response times aren't great sometimes. But the majority of the time I think we all listen to each other. I've never had any major issues.' C 6
Health visitors Social workers	'Sometimes it's frustrating because things do not happen because everyone's got busy caseloads so sometimes things do not get followed up as quickly as you would like.' HV 4
	'It can be difficult to get answers, get doctors pinned down to speak to you and it's because they are so busy themselves and have not really got time but when we have got a child protection concern it's quite key really that time is given to us.' SW 13
Different threshold criteria	
Health visitors	'I think the biggest challenge is if I think it's met a threshold and CSC do not think it meets that threshold and they just see the snapshots whereas you have experienced it quite regularly. It seems children's services thresholds are so high that you are always at the point what does this parent have to do to this child to get them removed?' HV 5
Social workers	'We have thresholds we have to adhere to and sometimes health visitors can think this is going into child protection and then you sit and break it all down and go through it all and you realise no it might be high end care and support, that it has not tipped the threshold for child protection yet and sometimes you can be at loggerheads over those decisions.' SW 16
Disagreements between professionals	
ED clinicians	'We've made retrospective children's safeguarding referrals highlighting our concerns and these have not been followed up so there have been a handful of retrospective cases where I thought more could have been done from the children's services side of things.' C 3
Social workers	'There are times where the doctor is saying this is child protection, and actually we have done our investigation, police have done their investigation, it's not safeguarding and they just cannot get that.' SW 11

and raise these with CSC, but not to make the final decision. Meanwhile, SWs emphasised that decisions around safeguarding are always made in collaboration with other disciplines, and they rely on clinicians to tell them whether a burn injury is likely abusive or accidental.

Professionals' understanding of the roles and responsibilities of other disciplines

HVs felt that there was a lack of understanding from ED clinicians and SWs regarding HVs' roles and particularly their level of involvement in safeguarding children. HVs expressed frustration about being instructed to reinforce safety

FACTORS INFLUENCING CLINICIANS', HEALTH VISITORS' AND SOCIAL WORKERS' PROFESSIONAL JUDGEMENTS, DECISION-MAKING AND MULTIDISCIPLINARY COLLABORATION WHEN SAFEGUARDING CHILDREN WITH BURN INJURIES: A QUALITATIVE STUDY

Association of Child Protection Professionals

11 of 18

advice, when this is part of their everyday responsibilities, and thought that this could also be done by clinicians in the ED. HVs felt that SWs take advantage of the regular contact that HVs have with their families to pass on some safeguarding responsibilities. There is a clear tension between the two disciplines here, as likewise, SWs felt that HVs can shirk their safeguarding responsibilities as soon as CSC becomes involved. SWs felt that it was sometimes more appropriate for HVs to work with a family as they often have a better rapport with them. SWs felt that ED clinicians have extremely high expectations of them and presume that CSC will visit every child referred. They reported that ED clinicians often ask them to assess a child or family when this is not always necessary.

Professionals' expectations of other disciplines

Some ED clinicians reported that they expect HVs to conduct a home visit if they notify them of a child with a burn injury, and some stated that this is because the ED is not an appropriate setting to provide safety advice. However, one clinician said that they expect HVs to use their own professional judgement and knowledge of the family when deciding how best to follow them up. Similarly, while some ED clinicians reported that they expect a SW to visit the family home and conduct further investigations if they refer a child with a burn injury, others thought that the response should depend on the individual circumstances of the case.

Conversely, HVs reported that they expect clinicians to give out safety advice in the ED at the time of the incident, although some acknowledged that this can be difficult. Some HVs felt that, in some cases, clinicians should refer the child to CSC rather than simply notifying their HV, while others felt it was unrealistic to expect clinicians to notify HVs of every child with a burn injury. Likewise, SWs reported that they expect clinicians to take responsibility for making referrals if they have safeguarding concerns and to communicate their concerns to the family. SWs also declared their expectation that clinicians give them as much background information as possible when making a referral, including contextual information about the incident and the parent–child relationship, and a clear opinion on whether the injury was accidental or abusive.

Theme 2: Factors influencing judgement of risk and decision-making

Gathering information

Professionals from all three disciplines stated that they gather as much information as possible and consider a combination of multiple factors when judging risk and making safeguarding decisions in paediatric burn injury cases. Factors mentioned by all three disciplines included whether the history fits with the child's explanation, the severity of injury and/or the age/developmental capabilities of the child; whether the history is consistent between caregivers and/or over time; delay in seeking care; the circumstances surrounding the injury; experience of safeguarding and/or burn injuries; knowledge of the clinical features of abusive/neglectful burns; whether there had been previous safeguarding concerns or previous involvement with CSC; concerns about lack of supervision or neglect; the behaviour and reactions of the parents/caregivers; parent–child interaction; and support and advice from colleagues.

Quality of information in the referral/notification

HVs and SWs reported that a major factor influencing their judgements and decision-making in paediatric burn injury cases is the quality of information received from ED clinicians. The less information and context received, the more likely it is that the HV will conduct a home visit.

Social history and risk factors

SWs explained that while medical evidence is a crucial part of their investigation, they are heavily influenced by the judgements and decisions of clinicians in terms of injury plausibility. Meanwhile, SWs reported that they must also consider wider factors such as the families' social history and assess any future risks to the child. Although social history was touched on by some HVs and clinicians, SWs were the only discipline who specifically discussed risk factors such as substance abuse, domestic violence and parental mental health.

Knowledge of the family

By far the most important factor influencing HVs' risk judgements and decision-making is their knowledge of the family. HVs stated that if they knew the family well they may be more inclined to conduct a telephone appointment rather than a home visit, whereas if the family were new to them then they would visit the home to discuss the burn injury.

Knowledge of the clinical features of abusive or neglectful burn injuries

Clinicians reported that they rely on their knowledge of the clinical features of abusive and neglectful burns when making safeguarding judgements and decisions, and that they regularly used the digital records system maintained by HVs (PARIS) to check whether there were any previous safeguarding concerns in the family (see Appendix S1 for further information about the PARIS system). Some clinicians also reported using the BuRN-Tool (Kemp et al., 2018) to aid their decision-making, a clinical tool that provides a risk score and corresponding safeguarding recommendations based on combinations of child and injury characteristics. While SWs and HVs reported having some knowledge of the clinical features of abusive and neglectful burns, many stated that they would like more training, though they acknowledged that they would still look to clinicians for their opinion, as it is their area of expertise.

Theme 3: Information sharing between disciplinesThe quality of information received from ED clinicians by HV and SW

All HVs and SWs agreed that the quality of information that they receive from clinicians when a child presents to the ED with a burn injury is generally very poor, although some participants pointed out that referrals are more detailed when there are 'obvious' child protection concerns.

Information that HV and SW require

HVs and SWs emphasised the need for much more information, and particularly more contextual information, in the notifications and referrals, to help them with their judgements and subsequent decision-making. In addition, social workers stressed the need for clinicians to discuss their concerns with the family and to obtain consent from the parent(s) before making a referral.

Organisational barriers to information sharing

Several organisational barriers to information sharing were identified, including different working patterns, different IT systems, outdated paper-based systems and inconsistent use of safeguarding databases. Many participants, particularly HVs, reported that they spend a considerable amount of time chasing other professionals for information, including basic information such as parents' contact details.

Suggestions for improvement

Suggestions for improvement included having SWs present at weekly clinical safeguarding meetings, standardised use of databases, referral forms and IT systems and regular feedback on individual cases.

Referrals for information sharing versus referrals for support/safeguarding

Finally, there was a clear distinction between referrals made for support/safeguarding purposes and referrals made purely for information sharing purposes. Some clinicians said they would always refer a child to CSC if the child had any previous social care involvement, even in the absence of current safeguarding concerns. Clinicians and HVs felt that such referrals are important to build a picture that may eventually meet a threshold for assessment and/or intervention. However, while SWs appreciated why this information may be helpful, they did not want to be viewed as a 'logging service' and felt the onus should be on the individual professional to raise their concerns once a threshold had been met.

FACTORS INFLUENCING CLINICIANS', HEALTH VISITORS' AND SOCIAL WORKERS' PROFESSIONAL JUDGEMENTS, DECISION-MAKING AND MULTIDISCIPLINARY COLLABORATION WHEN SAFEGUARDING CHILDREN WITH BURN INJURIES: A QUALITATIVE STUDY

Association of Child Protection Professionals

13 of 18

Theme 4: Barriers and facilitators to successful multidisciplinary collaboration

Communication

Participants across the board reported a mix of positive and negative experiences of multidisciplinary collaboration. HVs in particular expressed several difficulties with communication and procuring information and feedback about children with burn injuries from clinicians and social workers. Professional understanding of the roles and responsibilities of other agencies was reported as a clear facilitator of successful multidisciplinary working.

SWs and HVs reported that strategy meetings are extremely helpful for bringing professionals together and facilitating communication between different agencies. Strategy meetings promote multiagency discussions to plan next steps when it is suspected that a child is suffering or is likely to suffer significant harm. HVs felt that they had an important role to play at these meetings, as they often had a long history and extensive knowledge of the family compared to other professionals. Similarly, participants noted that the implementation of Multiagency Safeguarding Hubs (MASH) has enhanced communication between disciplines. These hubs unite a range of professionals, including SWs, police and health professionals, into an integrated team to facilitate timely and effective information gathering and sharing in cases where there are safeguarding concerns. Further detail regarding MASH is provided in Appendix S1.

Many SWs remarked that it can be difficult to obtain a clear opinion from a clinician regarding whether a burn is abusive or accidental, while one social worker reported that they had not experienced this.

Pressure on public services/caseloads

There was an appreciation from all disciplines that professionals working in the public sector are under immense pressure with increasingly large caseloads, which can cause delays with follow-up, information sharing and investigations. However, participants noted that timely follow-up of the family by all agencies is crucial when there are safeguarding concerns.

Different threshold criteria

It was evident that there is a conflict between health professionals and CSCs in terms of the thresholds required to initiate child protection procedures. Clinicians' and HVs thresholds for intervention tend to be much lower than those of SWs which can create tension, particularly between HVs and SWs, as HVs work with families over a long period of time and can feel that they know the situation better.

Disagreements between professionals

Similarly, a significant barrier to successful multidisciplinary collaboration is when professionals from different disciplines disagree about whether a burn injury is abusive or accidental and the level of intervention required. Clinicians noted that a particular challenge is getting SWs to follow up safeguarding concerns that they have raised retrospectively after reviewing cases at their weekly paediatric burns safeguarding meetings.

DISCUSSION

This study suggests a general lack of understanding and frustration between the three professional groups about the roles and responsibilities of each one when it comes to safeguarding children who present to the ED with burns. The expectations that each professional group had of the others were high and deemed unrealistic by the study participants. This was particularly evident between HVs and SWs in terms of who should be providing family support and intervention. All groups reported that they collect and assess as much information as possible to inform their decision-making. However, each agency is privy to different information drawn from their individual exposure to the child and family, and they are dependent on one another to understand the full picture, with the most critical information often known to the HV due to their long-term contact with the family in the home. Despite this, information sharing was felt to be poor at the points of referral and was hindered by several organisational barriers and resource constraints. Poor information sharing may explain why referral pathways were difficult to follow from clinical records in our previous

study examining the impact of the BuRN-Tool on social care outcomes which included many of the same local authorities and health boards (Bennett et al., 2023).

In terms of barriers and facilitators to multidisciplinary working, the themes we identified were similar to those found in many previous studies of multidisciplinary collaboration across different professions and contexts, for example, the need to better understand one another's roles, and the importance of systemic factors (Darlington et al., 2005; Frost et al., 2005). However the current study has also highlighted the importance of providing as much context as possible when sharing information between disciplines in children's burn injury cases, given the complexities and nuances of such cases, and has highlighted particular tensions between health visitors and social workers when it comes to responsibilities and thresholds for intervention.

Similarly, in terms of factors influencing decision-making and professional judgements, the findings were similar to those of a previous study investigating factors influencing decision-making in suspected abusive head trauma cases (Cowley et al., 2018). In both studies, professionals discussed medical factors such as knowledge or lack of knowledge of the clinical indicators of abusive injuries, circumstantial factors such as the history provided and family factors such as the social history and knowledge of the family. Professionals in both studies also emphasised the importance of integrating all of these factors and building a holistic picture in order to make a judgement or reach a decision. Previous studies have also highlighted that child protection social workers are often provided with low-quality information (e.g. Kirkman & Melrose, 2014); the current study confirms that the quality of information provided to both social workers and health visitors is generally poor when a child presents to the ED with a burn but that the quality of information is one of the most important factors influencing the judgements and decisions of both health visitors and social workers. Unsurprisingly, clinicians reported being heavily influenced by the clinical characteristics of the burn injury, but also found it helpful to have access to the family's history through the health visiting database (PARIS). Social workers reported being influenced by parental risk factors but were also reliant on clinicians' medical opinions, Health visitors were heavily influenced by their prior knowledge of the family.

Formal opportunities for multiagency team working such as strategy meetings and MASH hubs were perceived as facilitators of more successful collaboration with the potential to improve communication and information sharing. Professionals from the different groups valued the opportunity to bring their own viewpoint to the table and triangulate their knowledge at these meetings. However, such meetings often take place after a case has been referred to CSC. Further opportunities for multiagency working may therefore be beneficial at the referral/notification stage. Clinicians at one ED in this study reported that they discuss all paediatric burns at their weekly safeguarding meetings and noted challenges in getting SWs to attend, but following a stakeholder event conducted as part of the BuRN-Tool study, HVs and ED clinicians agreed to work together more closely and discuss paediatric burn cases on a regular basis. However, it is recognised that establishing multiagency approaches to safeguarding is complex, and requires careful planning, monitoring and evaluation to measure outcomes and effectiveness (Sloper, 2004; Shorrock et al., 2020).

A major finding of this study was that all three disciplines identified a lack of understanding of their roles by the other groups. This sentiment has been echoed in previous qualitative studies (Cowley et al., 2018; Lalayants, 2008) and suggests that enhancing multiagency safeguarding training in paediatric burn injuries may be beneficial. Evaluation of an interprofessional child protection training programme found that the training helped to clarify different roles and improvements in communication were attributed to a better understanding of each other's work and the limitations of each agency (Watkin et al., 2009). Another evaluation of a training programme for clinicians that aimed to increase understanding of the function of child protection SWs found that the programme led to greater collaboration between clinicians and SWs (Itzhaky & Zanbar, 2014). Similarly, other initiatives aiming to increase training of health professionals in child protection and improve communication and data sharing between health professionals and children's services were well received, and particularly welcomed by professionals working in emergency medicine (Maier et al., 2020; Sethi et al., 2018). However, we acknowledge that while there is some evidence that interprofessional training programmes can improve joint working, there have been limited evaluations in this area and therefore the evidence base remains weak (Yamaoka et al., 2019).

SWs described being heavily reliant on clinicians' opinions regarding whether a burn is abusive or accidental, and reported frustration that clinicians are sometimes unable to provide a clear opinion. This is consistent with the findings of previous studies exploring multidisciplinary collaboration in the context of abusive head trauma and abusive bruising (Cowley et al., 2018; Matthews et al., 2017). This issue has been discussed in a briefing intended to support practitioners by identifying difficult issues in multiagency safeguarding work (Social Care Institute for Excellence, 2016a). Suggested solutions include adapting medical report forms to encourage doctors to mark the probability of different potential causes of an injury, and training sessions for other professionals on differential diagnosis (Social Care Institute for Excellence, 2016a).

Two of the most important factors influencing HV decision-making were the quality of information received from clinicians and the HVs' knowledge of the family, both of which determined whether HVs would conduct a home visit or not. Previous research has shown that over half of notifications to HVs about ED attendances for child injury did

FACTORS INFLUENCING CLINICIANS', HEALTH VISITORS' AND SOCIAL WORKERS' PROFESSIONAL JUDGEMENTS, DECISION-MAKING AND MULTIDISCIPLINARY COLLABORATION WHEN SAFEGUARDING CHILDREN WITH BURN INJURIES: A QUALITATIVE STUDY

Association of Child Protection Professionals

15 of 18

not result in any action (Kendrick et al., 2001). A survey of 82 HVs of children who attended an ED with a burn found that information contained in notifications was variable and lacking in detail, and HVs had to use their own knowledge of the family to inform decisions regarding further action (Saunders et al., 2011). A recent study demonstrated that, for children attending ED settings with a burn, key risk factors for child maltreatment included on a standardised, evidence-based burns proforma were often not identified or recorded by ED clinicians (Nuttall et al., 2020). The study concluded that assessment of maltreatment risk in the context of paediatric burns could be improved if ED clinicians had access to HV records and risk factor information (Nuttall et al., 2020).

This study found instances of disagreement between HVs and SWs in terms of thresholds for CSC involvement. Analysis of serious case reviews found that thresholds for CSC intervention may be high because of pressures on the system and heavy workloads (Social Care Institute for Excellence, 2016b). If thresholds are not met, an HV may become the sole worker involved with high-risk families, which can cause anxiety and concern both for the families who are not receiving adequate social care, and other families for whom the HV is responsible, who may be receiving less support as a result (Cowley et al., 2013). Possible solutions include the introduction of 'threshold moderation meetings', double screening of referrals, feedback on referrals, training and support for professionals making referrals and encouraging professionals to challenge decisions and escalate concerns where necessary (Social Care Institute for Excellence, 2016b).

Strengths and limitations

To our knowledge, this is the first study to examine decision-making and multidisciplinary collaboration with these professional groups in the context of paediatric burn injuries. The strengths of this study lie in the wide range of professionals interviewed, the richness of the data and the robustness of the data analysis. While this study focused on burn injuries, many of the findings are likely to be applicable to a wider range of safeguarding cases where children present to the ED with injuries. This is because the safeguarding processes and procedures to be followed are the same regardless of injury type. HVs are notified when a child on their caseload presents to the ED with any injury, and all professionals are responsible for making a referral to CSC if they suspect that any injury is abusive (Department for Education, 2018).

It is important to note that this study was conducted prior to the COVID-19 pandemic, which has likely brought additional challenges (and perhaps some benefits) to information sharing and multidisciplinary collaboration in child safeguarding cases. The data represent the opinions of professionals rather than observations of their practice, and participants may have felt obliged to give socially acceptable answers. In addition, we did not conduct any patient or public involvement work with children or parents, whose perspectives may have provided additional insight into decision-making processes when a child presents to the ED with a burn. Although every effort was made to build a rapport with participants, at times the interviewer felt that some participants became defensive as they may have felt they were being tested or judged. Qualitative research inevitably relies on the researcher's interpretations; however, one author coded all the data, while three others coded subsets, to ensure that concepts were not missed and to gain insights from multiple perspectives.

Recommendations for practice

We recommend that clinicians, SWs and HVs revisit and enhance their ways of working together, in order to build bridges, and a greater understanding of each other's roles. This could be done via an interprofessional training programme aimed at improving multidisciplinary collaboration. Any training programme should be robustly evaluated to investigate cost effectiveness, the impact of the programme on child services outcomes as well as the mechanisms of impact (Sloper, 2004). In addition, SWs could be embedded in ED departments to work directly with health colleagues, and a trial conducted to evaluate effectiveness. A recent mapping review suggested that health and social care services aiming to improve awareness of safeguarding issues may benefit from service development interventions that go beyond high-quality training provision (Chambers et al., 2021). Another recent study found that the implementation of a multidisciplinary model whereby all paediatric burns were evaluated by an internal child protection team may provide a more consistent and reliable method of identifying abuse cases (Nigro et al., 2018). SWs and HVs would benefit from further training in the clinical features of abusive and neglectful burns. ED clinicians should work to improve the level of detail and context that they provide when notifying a HV about burn injuries in young children or making a child protection referral to CSC. Likewise, all professionals could improve information sharing by providing regular feedback on individual cases and attending multidisciplinary meetings.

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CONFLICT OF INTEREST STATEMENT
None.

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FACTORS INFLUENCING CLINICIANS', HEALTH VISITORS' AND SOCIAL WORKERS' PROFESSIONAL JUDGEMENTS,
DECISION-MAKING AND MULTIDISCIPLINARY COLLABORATION WHEN SAFEGUARDING CHILDREN
WITH BURN INJURIES: A QUALITATIVE STUDY

Association of
Child Protection
Professionals

17 of 18

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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