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## HS&DR Evidence Synthesis Centre Topic Report

# Recognition of risk and prevention in safeguarding of children and young people: a mapping review and component analysis of interventions aimed at health and social care professionals

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## This report

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## Abstract

**Background:** The term ‘safeguarding’ refers to measures designed to protect health, wellbeing and human rights, allowing people (especially children, young people and vulnerable adults) to live without fear of abuse, harm or neglect. The Children Act 2004 placed a responsibility on key agencies, including those in health and social care, to have regard to the need to safeguard children and promote their welfare.

**Objectives:** To address the question ‘What interventions are feasible/acceptable, effective and cost effective in:

- improving health and social care practitioners' recognition of children or young people who are at risk of abuse?
- improving recognition of co-occurring forms of abuse where relevant?
- preventing abuse in these groups?‘

**Data sources:** Fourteen health and social care databases were searched from 2004 (date of Children Act) to October 2019.

**Methods:** This mapping review included an extensive literature search, independent study selection, extraction of study data and quality assessment of study design features. The research was carried out in two stages. We systematically retrieved and coded UK research and policy documents to gain a contemporary picture of safeguarding issues and practice. We also identified systematic reviews or narrative reviews that reported safeguarding practice from other high-income countries. Studies were summarised using narrative synthesis in four pre-defined groupings. A further grouping of policy/guidance documents was added based on examination of the evidence retrieved.

**Results:** The review included 179 papers (Strategies=15; Policy/Guidance=36; Cultural/Organisational=31; Initiatives=69 and Reviews=28). There were four empirical evaluations of strategies (‘what to do’) and 54 of initiatives (‘how to do it’). Most initiatives fell into three categories: training, service development and use of data. Promising initiatives included liaison nurses; assessment clinics; secondment; joint protocols; and a ‘hub and spoke’ model. Approaches using routinely collected data also appeared promising. However, the evidence base comprised mainly cross-sectional or before/after studies with no control

group, providing  little hard evidence of effectiveness. Barriers to effective implementation of safeguarding strategies were identified at all levels of the health and care system.

**Limitations:** We used a number of methods to abbreviate the review process. Limitations of the evidence base included lack of long-term follow-up, control groups and data on service-relevant outcomes.

**Conclusions:** The UK and international literature documents increased awareness and activity in relation to safeguarding. A limited number of types of interventions have been reported and generally these lack rigorous evaluation. In particular, the user voice is muted in relation to experience of different interventions or services. Taken as a whole the topic of child safeguarding seems to be lacking a whole system approach which would facilitate a more joined-up approach.

**Future work:** Future research questions centre on the need to balance multi-agency training and development initiatives with the specific needs of individual health and social care professional groups.

**Funding:** NIHR Health Services & Delivery Research Programme (project number HSDR16/47/17).

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## List of abbreviations

| Acronym | Definition |
|---|---|
| A&E | Accident & Emergency |
| ASSIA | Applied Social Sciences Index and Abstracts |
| CALFB | child abuse linked to faith or belief |
| CASP | Critical Appraisal Skills Programme |
| CINAHL | Cumulative Index to Nursing and Allied Health Literature |
| CPU | Child Protection Unit |
| CSA | Child sexual abuse |
| CSE | child sexual exploitation |
| ED | Emergency department |
| FGM | female genital mutilation |
| HS&DR | Health Services & Delivery Research programme |
| IBSS | International Bibliography of the Social Sciences |
| IMAAF | International Multi Agency Assessment Framework |
| JBI | Joanna Briggs Institute |
| LSCB | Local Safeguarding Children Board |
| NICE | National Institute for Health and Care Excellence |
| NIHR | National Institute for Health Research |
| NSPCC | National Society for the Prevention of Cruelty to Children |
| PPI | Patient and public involvement |

| Acronym | Definition |
|---|---|
| SCT | Social Cognitive Theory |
| TiDIER-Lite | Template for intervention description and replication-Lite (simplified) |

## Plain English summary

Large numbers of children are badly treated at home, school and in the community. Being badly treated causes physical harm and affects children's minds and feelings. The police and those planning and delivering health and social care services have a duty to protect ("safeguard") children from being badly treated. They need to take action to help children to have the best of possible health outcomes.

We looked at studies from the UK about different ways of organising services and how to advise health and social care staff when they meet a child needing help or protection. We also looked to see what we could learn from good examples of projects and policies from other countries.

Our review included 151 UK research studies and policy or guidance documents and 28 reviews of international evidence. Most studies were quite well conducted but there were some common limitations. These included lack of a control group and only measuring outcomes over a short time period. We found that different health and social care staff have different needs for information and training depending on whether they are front-line staff, whether they deliver general health and social care services or whether they maintain an ongoing support role in relation to child safeguarding.

We found that most studies recommend that different organisations try to work closely together. Few studies have tried to find out what the children or their parents and other carers wanted from the safeguarding process. Children who need safeguarding may be looked after by several different organisations; it may be difficult for them to receive consistent care and support. Staff members need training, good staff communication, joined-up working and accurate record-keeping.

# Scientific summary

## Background

The Children Act 2004, as amended by the Children and Social Work Act 2017, places duties on key local agencies (specifically, the police, clinical commissioning groups and the local authority) to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of children in their area. The 2004 Act also established statutory Local Safeguarding Children Boards (LSCBs) (http://www.legislation.gov.uk/ukpga/2004/31/notes/division/1/1 (accessed 27 September 2019). The term 'safeguarding' refers to measures designed to protect health, wellbeing and human rights, allowing people (especially children, young people and vulnerable adults) to live without fear of abuse, harm or neglect.

This report focuses on safeguarding strategies, policies, procedures and interventions, with a focus on those in place in the United Kingdom. It also looks more broadly at the international context, specifically through the review literature.

## Objectives

This report aims to address the following question:

'What interventions are feasible/acceptable, effective and cost effective in:

- improving health and social care practitioners' recognition of children or young people who are at risk of abuse?
- improving recognition of co-occurring forms of abuse where relevant?
- preventing abuse in these groups?'

## Methods

The research was carried out in two stages. We systematically retrieved and coded UK research and policy documents to gain a contemporary picture of safeguarding issues and practice. We also identified systematic reviews or narrative reviews that reported safeguarding practice from other high-income countries. Similar methods of searching and study selection were used for both stages and quality assessment was performed where a

primary UK study utilised a recognised study design or where an international review article exhibited a degree of systematicity.

The review team searched fourteen health and social care databases (ASSIA - Applied Social Sciences Index and Abstracts, CINAHL - Cumulative Index to Nursing and Allied Health Literature, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials, HMIC - Health Management Information Consortium, IBSS - International Bibliography of the Social Sciences, MEDLINE, PsycINFO, Sociological Abstracts, Social Care Online, Social Policy and Practice, Social Services Abstracts, Social Sciences Citation Index, and Social Work Abstracts from 2004 (date of Children Act) to October 2019. Search results were uploaded to EPPI-Reviewer 4 (Evidence for Policy and Practice Information and Co-ordinating Centre, University of London, London, UK) for title and abstract screening. Screening was performed by a team of three reviewers.

To be included in the systematic review, studies must meet the following inclusion criteria:

**Population** – Children and young adults (aged up to 18) and/or other service users (family members or other carers) in health and social care settings.

**Intervention** - Interventions aimed at health and social care professionals looking after children and young adults (aged up to 18) in health and social care settings to:

- improve recognition by professionals of children who are at risk of experiencing physical, sexual or emotional abuse or neglect
- improve recognition of co-occurring forms of abuse where relevant
- prevent abuse in these groups. This may include training and awareness raising for professionals.

Studies with no intervention (e.g. qualitative studies) were included if they helped to explain why interventions and initiatives work or fail to work

**Outcomes** – Improved knowledge and understanding of (risk factors for) abuse among practitioners. Improved rates of early identification of possible abuse. Qualitative outcomes, including feasibility and acceptability of interventions to professionals and young people. Any reported data on costs, resource use or cost-effectiveness. Other outcomes of interest include explanatory factors for why interventions are thought to work and findings of relevant cultural/organisational studies.

**Comparator** – no intervention; comparisons with practice as usual were also eligible for inclusion.

**Study design** – we included primary literature from the UK (any design (quantitative or qualitative, including local service evaluations) meeting the preceding criteria and containing relevant empirical data). We also included reviews, whether systematic or narrative, that included international evidence.

**Other limitations** – For inclusion publications were required to be written in the English language and published since 2004 (the date of the Children Act).

Full papers were reviewed for all references that appeared potentially to meet the inclusion criteria. Screening of full texts followed a similar process to that for title and abstract screening. Queries were resolved by discussion. Systematic and non-systematic reviews were coded for separate analysis.

Data extraction (coding) was completed in EPPI-Reviewer 4 using a form that combined tick-box and open questions. Key data from the included studies, comprised study design, intervention/initiative (where applicable), population/setting, results and key limitations. We extracted details from policy/guidance documents using a purpose-designed form to reflect the different structure and contents of these documents. Data extracted were based in part on a safeguarding checklist produced by the National Society for the Prevention of Cruelty to Children.

Studies were also coded for their suitability for quality assessment using a formal checklist. Those studies selected for quality assessment were appraised using tools developed by the Joanna Briggs Institute, the CASP tool for qualitative studies or AMSTAR for systematic reviews. Quality assessment was performed by a single reviewer, with a 10% sample checked for accuracy and consistency. Assessment of the overall strength (quality and relevance) of evidence for each research question was incorporated within an accompanying narrative synthesis.

Narrative synthesis was based around five groupings of the literature:

- Strategies to increase awareness and promote prevention of abuse
- Component mapping of identified strategies and why they are thought to work
- Cultural/organisational studies including cross-referral and interfaces between different organisations/sectors
- Initiatives and descriptions/evaluations of current practice
- Analysis of policy and/or guidance documents.

The Sheffield Evidence Synthesis Centre public advisory group was involved throughout the project. In December 2019, we discussed the following questions with the group:

- which groups of health/social care professionals need to be aware of safeguarding children/young people?
- what might be the barriers to awareness and appropriate action?

Group members identified a wider range of health (particularly allied health) and care professionals in need of safeguarding awareness than that covered by the studies included in this review. The Group found it challenging to identify barriers, raising the possibility that this question might be more usefully be targeted via consultation with professionals.

**Results**

A total of 179 studies were included in the systematic review. The studies were organised into the following groups for analysis: Strategies=15; Policy/Guidance=36; Cultural/Organisational=31; Initiatives=69 and Reviews=28.

Overall, the studies included in the review were rated as having a moderate or low risk of bias. Twelve of the 21 reviews were suitable for quality assessment risk of bias; nine of these reviews were considered as systematic, one an integrative review and the remaining two were identified as 'literature reviews'. Included qualitative research studies exhibited either low or moderate threats to validity. Their most frequent limitation related to insufficient identification or exploration of the impact of the researcher on the responses of participants. This could be particularly important given sensitivities associated with this topic area. Other limitations included insufficient specification of ethical issues; however, this need not necessarily imply that their ethical quality itself was deficient. Quantitative studies exploring education and training generally possessed small samples and evaluation relied on non-objective measures of limited duration. The perspective of the children and/or young people appeared to be particularly lacking.

Twenty-two papers reporting on evaluations of individual initiatives were classified as suitable for component analysis using the TiDIER-Lite (Template for intervention description and replication-Lite) checklist. These comprised 11 evaluations of training, seven studies (eight papers) on service development and three studies on use of data.

The following themes were identified across the different groupings of literature:

- Proportionality of training was revealed as important, that is staff needed to be equipped to the degree that their role required it – whether to detect, to navigate and refer or to manage the ongoing consequences of safeguarding issues.

- At the same time, widespread benefits were suggested for inter-agency and multi-disciplinary training.
- Need for information systems that allow information-sharing and joined-up working between services.
- Need for improved communication between agencies and for better understanding of respective professional roles in safeguarding.

**Conclusions**

The review identified 179 papers that met the inclusion criteria. This sample offers a rich and diverse sample of contexts and interventions. Included studies were heterogeneous, covering different settings and sub-populations. Methodological quality was generally moderate to good.

This review was conducted rapidly by a small team. It included a thorough search, with follow-up pursuit of citations and used a structured framework approach to characterise interventions. Where possible, quality assessment was used to explore study quality; heterogeneity of study designs means that a checklist for quasi-experimental studies was used generically to explore studies.

The review identified the following **implications for health care or service delivery**:

Safeguarding is increasingly seen as "everyone's business" with each staff member who comes into contact with a vulnerable child having a potential role to play. However, this may unintentionally cause a blurring of responsibilities and a lack of definition of clearly delineated roles.

Promising initiatives supported by relatively strong evidence include liaison nurses, assessment clinics, secondment, joint protocols, and a 'hub and spoke' model.

Such initiatives tend to be characterised by clear lines of responsibility and operate across multiple services and/or sectors.

Effective interagency working is central to many of the identified initiatives. This relates particularly to communication, information sharing and information systems. Joint- and joined-up education and training not only offers economies of provision but, more importantly, offers opportunities to create shared values and understanding and a clearer picture of respective professional roles.

Developing and providing training for health-care professionals could potentially improve the management of safeguarding issues and concerns. However, little evidence existed on the short- and long-term effectiveness of training and education nor, equally importantly, how such training might best be configured or delivered. At a time characterised by austerity it is challenging to secure staff attendance at external training events.

An organisational culture of "blame" is unhelpful. Organisations should focus on creating a positive environment within which the holistic needs of child and family can be collectively considered.

Review findings support the following **recommendations for research**:

- There is a need for continued mapping and evaluation of service initiatives building on the work of Luckock et al.[1] Longer term studies with outcomes relevant to service users are needed.
- Initiatives to support inter-agency working could benefit from further research. Examples include secondment of staff between health and social care; professional roles with a mandate to support joint working and information sharing; and use of joint protocols by health and social care professionals.
- Research is also needed to optimise the use of routinely collected data to support the identification of children and young people who may be at risk of abuse. This could involve development of innovative tools but improvements in the quality and consistency of data coding would also be a valuable research topic.
- Involvement of children/young people and family/carers in research and intervention design is essential and may also inform design of training curricula.
- Evaluations should include investigation of costs/resource use and barriers to implementation.
- Common interventions e.g. education and training, information sharing, documentation are typically not rigorously evaluated and further research on these should be considered.
- Study design should be as rigorous as possible: if a control group is not feasible, researchers could consider using a time series design or benchmark against other similar areas.
- Use insights from adult learning theory/cultural studies/theory to inform research and intervention development.

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# Chapter 1: Background

The term ‘safeguarding’ refers to measures designed to protect health, wellbeing and human rights, allowing people (especially children, young people and vulnerable adults) to live without fear of abuse, harm or neglect. The term is primarily used in the UK and Ireland, although the underlying concept is relevant to all health and care systems. The Children Act 2004 placed a responsibility on key agencies to have regard to the need to safeguard children and promote their welfare. The Act also established statutory Local Safeguarding Children Boards (LSCBs) (http://www.legislation.gov.uk/ukpga/2004/31/notes/division/1/1 (accessed 27 September 2019).

Child protection is a ‘devolved matter’ within the UK and each nation (England, Scotland, Wales and Northern Ireland) has its own system with associated legislation and guidance (https://learning.nspcc.org.uk/child-protection-system, accessed 11 May 2020) In England, child protection falls under the Department for Education, with statutory ‘safeguarding partners’ (local authorities, clinical commissioning groups and police) acting at the local level. Scotland has a system of local authority Child Protection Committees that are responsible for multi-agency child protection policy, procedure, guidance and practice. Wales has regional safeguarding children boards, while Northern Ireland has a single organisation, the Safeguarding Board for Northern Ireland.

Many aspects of the child protection and safeguarding system have changed over time. For example, a substantial number of studies included in this review involved English Local Safeguarding Children Boards (LSCBs) which were abolished from 2018. However, in summarising research for this report we use the terms current at the time the research was conducted.

This report was commissioned by the NIHR HS&DR programme from the Sheffield Evidence Synthesis Centre team, which provides a responsive rapid reviewing capacity to address topics identified as priorities for the NHS or to support commissioning of primary research. The aim of the project is to address an evidence gap identified in the NICE (National Institute for Health and Care Excellence) clinical guideline on child abuse and

neglect (https://www.nice.org.uk/guidance/ng76). The guideline committee noted a lack of evidence from the UK on recognition of risk and prevention of female genital mutilation (FGM). Following discussion among the HS&DR programme team, we were commissioned to review the broader topic of recognition of risk and prevention of abuse in safeguarding of children and young people. This broader scope reflects a recognition that health and social care decision-makers in all settings could benefit from a review of interventions to promote recognition of possible abuse (of all types) and ultimately its prevention.

The focus of this review is on organisational and cultural factors that help or hinder health and social care professionals in recognising risk of abuse. This includes provision of information and training to raise people's awareness of risk factors and possible signs of abuse or neglect but also covers the wider health and care system. Examples of relevant organisational and system factors include co-operation between different organisations and professional groups, and the use of information and data to promote safeguarding. Accuracy/effectiveness of risk assessment tools and scales are not the focus of interest.

Safeguarding of children and young people takes place in a wide variety of settings, including schools, colleges, sports clubs and other youth organisations. This review is restricted to health and social care settings but nevertheless includes a wide range of settings in primary, secondary and community care as well as local authority children's services. In developing the protocol, our working assumption was that relevant interventions were likely to be multi-component initiatives at the organisational or system level, but simple initiatives were also eligible for inclusion, as were studies that shed light on the cultural and organisational context of intervention delivery. Such studies could potentially help to explain variations in awareness and willingness to respond to possible child safeguarding issues within and between organisations.

# Chapter 2: Methods

## Research question

The review aimed to address the following research question:

What interventions are feasible/acceptable, effective and cost effective in:

- improving health and social care practitioners' recognition of children or young people who are at risk of abuse?
- improving recognition of co-occurring forms of abuse where relevant?
- preventing abuse in these groups?

To answer this question requires an understanding not only of the interventions themselves but their theoretical basis and the social and cultural context of intervention delivery. We defined recognition to include the ability to exchange information and data within the health and care system and to take appropriate action (e.g. referral to a paediatrician or to social services).

## Literature search and screening

A comprehensive literature search was conducted in October 2019. The search was developed on Medline and uses a range of MeSH headings and free-text terms. The search comprised four broad facets - child abuse, safeguarding and child protection, early help and recognition and health and social care professionals. Search filters were utilised to ensure retrieval of review studies and primary studies conducted in the UK. The search was limited to papers in English published from 2004 (date of Children Act http://www.legislation.gov.uk/ukpga/2004/31/contents) to October 2019. The MEDLINE search was translated to the other databases. The following databases were searched:

- ASSIA (Applied Social Sciences Index and Abstracts) via ProQuest (1987 - present)
- CINAHL (Cumulative Index to Nursing and Allied Health Literature) via EBSCO (1981 - present)
- Cochrane Database of Systematic Reviews via Wiley Interscience (2003 - present)
- Cochrane Central Register of Controlled Trials via Wiley Interscience
- HMIC (Health Management Information Consortium) via OpenAthens (1983 - present)

- IBSS (International Bibliography of the Social Sciences) via ProQuest (1951 - present)
- MEDLINE via OvidSP (1946 – present)
- PsycINFO.via OvidSP (1806 - present)
- Sociological Abstracts via ProQuest (1952 - present)
- Social Care Online (1980s - present)
- Social Policy and Practice via OvidSP (1981 – present)
- Social Services Abstracts via ProQuest (1979 - present)
- Social Sciences Citation Index via Web of Knowledge via ISI (1956 - present)
- Social Work Abstracts via EBSCO (1965 - present)

All of the references were imported into Endnote (EndNote X9.2) and then automatic and manual deduplication was conducted.

An example search strategy from MEDLINE is provided in Appendix 1 with details of how the different facets of the search were combined.

Additionally, citation tracking of the include national policy and guidance documents was conducted on Google Scholar. Searches for UK grey literature were conducted during the main database searches as both Social Care Online and Social Policy and Practice indexed grey literature.

Search results were downloaded to a reference management system (EndNote X9.2) and duplicates removed. Unique references were imported into EPPI-Reviewer 4 software for screening and analysis. Titles/abstracts of imported references were screened against the inclusion criteria. A 10% sample of excluded references was checked by a second reviewer to ensure consistency and guard against premature exclusion. References that appeared potentially relevant were screened as full text for a final decision on inclusion or exclusion. Uncertainties were resolved by discussion among the review team.

## Inclusion and exclusion criteria

## Inclusion

**Population:** Children and young adults (aged up to 18) and/or other service users (family members or other carers) in health and social care settings.

**Intervention:** Interventions aimed at health and social care professionals looking after children and young adults (aged up to 18) in health and social care settings to:

- improve recognition by professionals of children who are at risk of experiencing physical, sexual or emotional abuse or neglect
- improve recognition of co-occurring forms of abuse where relevant
- prevent abuse in these groups. This may include training and awareness raising for professionals.

Studies with no intervention (e.g. qualitative studies) were included if they helped to explain why interventions and initiatives work or fail to work.

**Comparators:** No intervention, practice as usual.

**Outcomes reported in studies:** Improved knowledge and understanding of (risk factors for) abuse among practitioners. Improved rates of early identification of possible abuse. Qualitative outcomes, including feasibility and acceptability of interventions to professionals and young people. Any reported data on costs, resource use or cost-effectiveness. Other outcomes of interest include explanatory factors for why interventions are thought to work and findings of relevant cultural/organisational studies.

**Study design:** Primary literature from UK (any design (quantitative or qualitative, including local service evaluations) that meets other criteria and contains relevant empirical data) plus reviews (systematic or narrative) of international evidence.

**Timeframe:** Publications in English since 2004 (date of Children Act)

## Exclusion

Descriptions and evaluations of routine (pre-qualification) training of health and social care professionals and studies of the accuracy/effectiveness of risk assessment tools and scales were excluded. Opinion pieces and other papers without empirical data were also excluded. Conference abstracts and articles in professional magazines were excluded unless they provided sufficient detail for quality assessment and data extraction

## Data extraction and quality/strength of evidence assessment

We extracted and tabulated key data from the included studies, including study design, intervention/initiative (where applicable), population/setting, results and key limitations. We extracted brief details of policy/guidance documents using a separate form to reflect the different structure and contents of these documents. Data extracted were based in part on a safeguarding checklist produced by the NSPCC (National Society for the Prevention of Cruelty to Children; https://learning.nspcc.org.uk/safeguarding-checklist/, accessed 27th January 2020).

Data extraction was performed by a single reviewer. Quality (risk of bias) assessment was undertaken for studies that used a recognised design for which an appropriate quality assessment tool was available. We used quality assessment tools provided by the Joanna Briggs Institute (https://joannabriggs.org/ebp/critical_appraisal_tools; accessed 29th January 2020), together with the CASP tool for qualitative studies and AMSTAR for systematic reviews. Quality assessment was performed by a single reviewer. Assessment of the overall strength (quality and relevance) of evidence for each research question formed part of the narrative synthesis.

## Evidence synthesis

We planned to perform a narrative synthesis of the literature under the following groupings:

- Mapping review of strategies to increase awareness and promote prevention of abuse
- Component mapping of identified strategies and why they are thought to work
- Cultural/organisational studies including cross-referral and interfaces between different organisations/sectors
- Examples of initiatives and descriptions/evaluations of current practice.

We distinguished strategies from initiatives on the basis that strategies are primarily about what to do and initiatives about how to do it. Initiatives are generally characterised by a finite project life cycle (including a summative evaluation) while strategies are often updated (evaluations of strategies are often formative to inform the next version). A further criterion was that strategies usually have multiple components while an initiative is more likely to focus on a single specific solution to an identified problem.

An additional grouping of policy/guidance documents was added based on examination of the evidence retrieved.

We planned to use the 5-item TIDieR-Lite checklist (By Whom, What, Where, To What Intensity, How Often) to map intervention components. This modification of the TIDieR framework was used by the authors in a previous review[2] Data extracted for policy documents and guidelines were based in part on a safeguarding checklist produced by the National Society for the Prevention of Cruelty to Children (NSPCC). We also planned to extract data on the theoretical basis of interventions/initiatives if reported and any specific behaviour change techniques used. Individual studies could appear in more than one section. Key findings that cut across the different sections were identified and drawn out in the discussion.

## Public and patient involvement

The Sheffield Evidence Synthesis Centre public advisory group was involved throughout the project. At our meeting in October 2019, we provided a brief introduction to the project. Group members edited and approved a plain English summary of the protocol. We also discussed how to make the review findings available and useful for a public audience. At the next meeting (December 2019), we presented a brief update, although the main finding was that the number of included studies was greater than expected and therefore no summary of results was available. We discussed the following questions with the group:

- which groups of health/social care professionals need to be aware of safeguarding children/young people?
- what might be the barriers to awareness and appropriate action?

Group members identified a wider range of health (particularly allied health) and care professionals in need of safeguarding awareness than that covered by the studies included in this review. This suggests a possible need for further research and/or interventions covering the needs of these groups and the children and young people they care for. The discussion of barriers was less fruitful and this might have been a more appropriate question for professionals than for a public group.

## Changes to protocol

A further grouping of policy/guidance documents was added to the narrative synthesis based on examination of the evidence retrieved.

## Registration and outputs

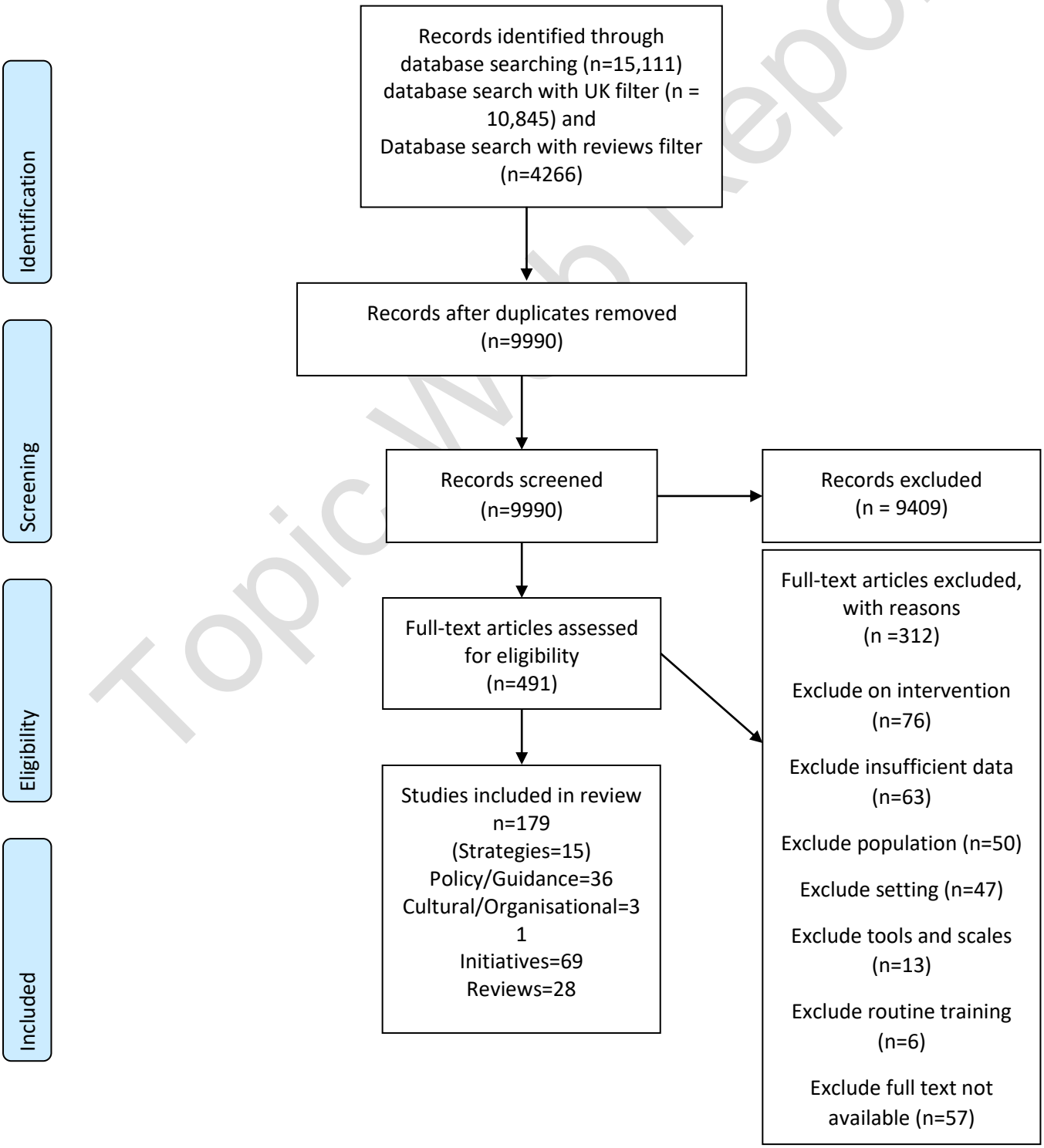
The protocol (dated 13 Nov 2019) was registered with the funder is available via the NIHR Journals Library website (https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/164717/#/). As the review is not primarily investigating health outcomes, registration on PROSPERO was not considered appropriate

# Chapter 3: Results

## Results of literature search

Chapter 3 presents the studies that were included in the review. A PRISMA diagram (Figure 1) details the search process.

Figure 1: PRISMA flow diagram



The database searches retrieved 10,845 references from the searches with the UK studies filter and 4266 references from the searches with the reviews filter. After deduplication in Endnote there were 10,311 references. The 10,311 references were imported in EPPI-Reviewer for article screening. The deduplication function in EPPI-Reviewer was utilised to remove a further 321 duplicates reducing the number of references to screen to 9990.

The first screen on title and abstracts included 491 for full-text screening and excluded 9409 references, most of which were clearly irrelevant but included one of the broad range of search terms used. Full-text screening was then conducted on 491 references. 179 references were included and 312 excluded. The 179 included studies were classified in the following categories:

Strategies – 15 studies

Policy/Guidance – 36 studies

Cultural/Organisational – 31 studies

Initiatives – 69 studies

Review – 28 studies

## Risk of bias and strength of evidence

### *Quality assessment of reviews*

Twelve review studies were suitable for quality assessment, full details of the quality appraisal are provided in Appendix 2 (Table 17). The reviews were assessed using AMSTAR, a tool to quality assess systematic reviews. Nine of the included reviews were systematic [3-11]. One quality assessment was completed for the two studies by Woodman et al as the later study was a paper [11] from the HTA Woodman, 2008 [10]. Three of the systematic reviews were very high quality reviews with none or only one of the methodological aspects assessed missing [6, 9-11]. The other systematic reviews were generally good quality. Common methodological aspects that were not present in the systematic reviews were 'a prori design' not provided [3-5, 12], duplicate study selection and data extaction not completed [5, 10, 11], grey literature not included [3, 4, 7, 8] and list of excluded studies not provided [5, 7-9] funding information or conflict of interest not provided [5]. Two of the reviews were literature reviews [13, 14] and one was an integrative review [15] for which many of the questions in the checklist

were not applicable. The literature reviews both had good searches and included grey literature. The integrative review had a good search and assessed and documented the quality of the included studies.

### *Quality assessment of qualitative studies*

The results of the quality assessment using the CASP checklist are summarised in Appendix 3 (Table 18).
The search and sift identified 21 qualitative studies for inclusion. Two of the included studies demonstrated high threats to validity. Nine studies had low threats to validity and were, therefore, considered of overall good quality. The remaining 10 studies revealed moderate threats to validity. Overall, therefore, the large majority of included qualitative studies were of moderate to good quality. This evidence profile therefore contributed to an overall high degree of certainty in the qualitative findings.

Studies performed most poorly with regard to not exploring the relationship between the researcher(s) and the research participants. There remains a possibility that participants may have been influenced by the position of the researcher when divulging their attitudes or opinions. This is of particular concern given the potential sensitivities that surround the topic of safeguarding. Where qualitative findings are potentially sensitive to context the reviewer should view findings with a degree of caution. Another item where studies performed particularly poorly was in regard to ethical issues. However, this relates to a lack of reporting of ethical issues and these limitations should not be construed as flaws in the ethics process. Overall the scientific quality of the design, data collection and data analysis is strong.

### *Quality assessment of other study designs*

Quality assessment of quasi-experimental and other study designs was performed with the JBI checklist for quasi-experimental studies. This included some studies of different designs but was preferred to using four or more different tools to assess a relatively small number of studies. The results are summarised in Appendix 4 (Table 19). The studies were diverse in design and subject matter, the largest group being evaluations of training initiatives using a before/after design. Only a few of these studies attempted to follow-up with participants to assess any longer-term effects of training.

The distinction between cause (intervention/exposure) and effect (Q1) was clear for most studies, with the exception of policy initiatives. Participants in comparisons (Q2) were similar for most studies as these were the same sample for before/after studies. None of the included studies had a control group (Q4) and only three reported repeated measurements before and after the intervention (Q5). Follow-up of participants was not relevant in some cases and only two studies achieved a positive response to most questions. Measurement of outcomes and statistical analysis (Q7–9) were satisfactory for most studies.

In summary, this group of studies represent weak evidence for effectiveness of interventions because of the lack of control groups and short or absent-follow-up in most cases.

## Strategies

### Mapping review

Strategies were defined as long-term, multi-component interventions that may be modified as a result of ongoing evaluation. We included 15 strategies in the review, including just four empirical studies. Study characteristics are summarised in Tables 1 and 2.

The empirical studies (Table 1) examined strategies at the national[16, 17], local (LCSB)[18] and hospital (ED) [19] level. Two studies involved analysis of data to explore national strategies. Chowdry et al.[17] argued that early intervention for child protection is a cost-saving approach compared with intervening later but the study was an indirect comparison based on economic modelling. By contrast, Gonzalez-Izquierdo et al. [16] used data on children's unplanned hospital admissions to compare England and Scotland, which adopted different legislation and policies after 2004–5. Results showed diverging trends in admissions between the two countries but the study could not establish whether this reflected differences in injury rates or in recording and responding to injuries. The relationship between national strategies and outcomes related to safeguarding needs further investigation, as noted by the authors (implications for policy are outside the scope of this report).

The other two empirical studies identified variation in safeguarding strategies among LSCBs[18] and among hospital EDs[19]. Pearce et al. concluded that the best approach to implementing national guidance on prevention of child sexual exploitation involved co-located multi-agency teams, while Sidebotham et al. presented recommendations for best practice based on their findings.

The remaining studies in this group (Table 2) examined co-operation between agencies[1, 20]; training/guidance [21-24]; and strategies for specific groups[25-27]. Two studies offer critiques of current strategies in relation to forced marriage[28] and FGM[29].

This group of studies covers a wide range of settings in health and social care. Most of the studies identify barriers to the effective implementation of safeguarding strategies at different levels in the system. These barriers include lack of supporting evidence [1, 21]; problems with

information sharing and IT[20]; inconsistent application of policies[23]; increased workloads[24]; lack of involvement of the communities affected[29]; and the wider policy environment[27, 28].

More positive findings came from an evaluation of the GIRFEC framework in Scotland[25] and of a strategy that takes account of peer group relationships as well as family circumstances in assessing safeguarding needs[26].

Table 1: summary of empirical studies of strategies

| Study | Setting | Professionals involved | Type of strategy | Type of evaluation | Outcomes related to awareness |
|---|---|---|---|---|---|
| Gonzalez-Izquierdo 2014[16] | NHS hospitals in England and Scotland | Not applicable | National policies and associated services for child maltreatment | Analysis of administrative data | Differing policies have resulted in diverging trends between countries |
| Chowdry 2015[17] | Health and social care in England and Wales | Not applicable | National policies on early and late intervention for young people | Analysis of spending on different intervention types | Prioritising early intervention better use of resources |
| Pearce 2014[18] | LSCBs in England | Multiple groups Practitioners from 24 LSCB areas | National guidance on safeguarding children from sexual exploitation | Cross-sectional (questionnaires and interviews) | Lack of awareness or resources meant only a quarter of LSCBs were pursuing both aims of the guidance (protecting children and prosecuting abusers) |
| Sidebotham 2007[19] | EDs in England and Northern Ireland | ED lead clinicians | Procedures for child protection | Cross-sectional | Approaches to identifying possible abuse were inconsistent |

Table 2: summary of non-empirical studies of strategies

| Study | Setting | Professionals involved | Type of strategy | Type of evaluation | Outcomes related to awareness |
|---|---|---|---|---|---|
| Luckock 2017[1] | Health and social care in England and similar health systems | Integrated teams | Innovative service models for neglect | Cross-sectional (scoping review) | Limited effectiveness evidence, importance of dialogue |
| Myers 2016[20] | Two LSCBs in England | Multiple groups<br>Senior LA leaders, practitioners and managers | Multi-agency response to child sexual exploitation | Cross-sectional (document review and interviews) | Need for better information sharing and IT systems |
| Bilson 2018[21] | LSCBs in England | Not applicable | Policies on bruising in pre-mobile children | Cross-sectional (review and survey) | Current policies not supported by evidence |
| Harris 2013[22] | General dental practice in Scotland | Dentists | Support for referral in cases of suspected abuse or neglect | Time series (2003 vs. 2010) | Dentists willing to get involved in detecting neglect |
| Harris 2017[23] | Community dental service in England | Dentists | Response to missed appointments | Before/after (audit) | Insufficient consistency in applying policies over time |
| Sheffield 2008[24] | NHS services in Barnsley | Multiple groups<br>Staff in primary care | Different levels of safeguarding training | Before/after | Implementation of strategy increased workloads due to ad hoc |

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|---|---|---|---|---|---|
| | | trust (PCT), foundation trust and primary care | | | training requests and providing extra support |
| Daniel 2016[25] | Health and social care in Scotland | Multiple groups Practitioners and managers from a range of agencies | Overarching framework, Getting it Right for Every Child (GIRFEC) | Cross-sectional (document review, interviews, focus groups) | GIRFEC framework combined with wider policies offers the potential for a more comprehensive and effective response to neglect |
| Firmin 2019[26] | Social care in England | Social workers | Assessing peer group relationships in safeguarding | Review of previous research | Awareness of peer relationships may aid safeguarding |
| Franklin 2013[27] | Social care in England | Multiple groups Social workers, managers, policy makers | Safeguarding of trafficked children in local authority care | Cross-sectional (interviews and survey) | Improving but many opportunities missed because of 'culture of suspicion' |
| Phillips 2004[28] | Social care/policy in the UK | Policy-makers/decision-makers | Policies towards children/young people at risk of forced marriage | Review of current or recent (in 2004) initiatives | Emphasis on exit from forced marriage has limitations |
| Plugge 2019[29] | Community in England | Community researchers | Policies for prevention of FGM | Cross-sectional (interviews and focus groups) | Involvement of communities in FGM prevention appears feasible |

## Component analysis

Only one strategy document was classified as suitable for component analysis using TIDieR-Lite[24]. This involved child protection training for health staff in the Barnsley area (data not shown).

## Policy/guidance

We identified 36 documents that were classified as policy or guidance (Table 3). The majority of these were produced by national governments (UK or devolved administrations), while five were produced by NHS bodies and seven by charities. The guidelines cover a wide range of topics including FGM, neglect, physical and sexual abuse, domestic abuse, radicalisation and trafficking. Only a few documents include consideration of service delivery and information sharing[30-33]. Citation searching of the included documents returned very few results, indicating that the policy/guidance literature had not been used and acknowledged by authors of research papers.

Table 3: summary of policy/guidance documents

| Reference | Country | Source | Coverage |
|---|---|---|---|
| Royal College of General Practitioners, Department of Health and Primary Care Contracting 2009 [30] | England | National government<br>NHS | Staffing and service delivery |
| Department of Health 2010 [34] | England | National government | Physical abuse<br>Sexual abuse/exploitation<br>FGM<br>Other harm/abuse<br>Domestic Violence<br>Forced Marriage |
| Franklin 2015 [35] | England | Charity<br>Funded/Commissioned by Comic Relief | Sexual abuse/exploitation<br>Young people with learning disabilities |
| National Multi Agency Child Neglect Strategic | UK | Other<br>National Multi Agency Child Neglect Strategic Work Group. The | Neglect |

| | | | |
|---|---|---|---|
| Work Group 2015 [36] | | group comprises of senior representation from the following stakeholders; Police, College of Policing, Department for Education, Public Health England, National Association of Head Teachers, OFSTED, Action for Children, NSPCC, Ministry of Justice, Assistant Director's of Children's Services, Local Safeguarding Children's Board, Local Government Association, National Health Service. | |
| Public Health England 2017 [37] | UK | National government<br>Public Health England | Sexual abuse/exploitation |
| Children's Society 2011 [38] | UK | Charity<br>The Children's Society | Other harm/abuse<br>Runaways |
| The Children's Society 2012 [39] | UK | Charity<br>The Children's Society | Other harm/abuse<br>Runaways |
| Chisholm 2017 [40] | UK | National government<br>Department for Education | Other harm/abuse<br>Radicalisation |
| Department of Health 2011[31] | England | National government<br>Department of Health | Physical abuse<br>Staffing and service |

| | | | |
|---|---|---|---|
| | | | delivery |
| The Scottish Government 2017 [41] | Scotland | National government | FGM |
| Co-Ordinated Action Against Domestic Abuse 2014 [42] | UK | Charity<br>Co-Ordinated Action Against Domestic Abuse | Other harm/abuse<br>Exposure to domestic abuse |
| ECPAT UK 2011[43] | UK | Charity | Other harm/abuse<br>Trafficking |
| Department for Education 2011[44] | England | National government | Child protection (general) |
| Department for Education 2014[45] | England | National government | Other harm/abuse<br>Trafficking |
| Scottish Executive 2004[46] | Scotland | National government | Child protection (general) |
| Intercollegiate Committee for Standards for Children | UK | NHS<br>Royal Colleges and other professional bodies | Child protection (general)<br>General guidance but |

| | | | |
|---|---|---|---|
| and Young People in Emergency Care Settings 2018[47] | | | includes section on safeguarding |
| Department of Health 2015 [32] | England | National government | FGM<br>Data recording/sharing |
| Department of Health 2017 [48] | England | National government | FGM |
| HM Government 2011 [49] | England<br>Wales | National government | FGM |
| Hoare 2016 [50] | Scotland | Charity<br>The RS MacDonald Charitable Trust | Physical abuse<br>Sexual abuse/exploitation<br>Neglect<br>Other harm/abuse<br>Emotional abuse |
| Scottish Government 2012[51] | Scotland | National government | Child protection (general)<br>Data recording/sharing |
| Scottish Government 2016[52] | Scotland | National government | Sexual abuse/exploitation |

| | | | |
|---|---|---|---|
| Scottish Government 2017[53] | Scotland | National government | FGM |
| Welsh Government 2018[54] | Wales | National government | Child protection (general) |
| Department of Health 2015[33] | UK | National government | FGM<br>Staffing and service delivery |
| Department of Health 2016[55] | UK | National government | FGM |
| Simpson 2012[56] | UK | NHS<br>Draws on the multiagency guideline published by the UK government in 2001, together with other clinical guidelines, reviews and articles, and experience of police and community workers. | FGM |
| Brown 2015[57] | England | Charity<br>NSPCC | Sexual abuse/exploitation<br>Limited data about |

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|---|---|---|---|
| | | | interventions aimed at health or social care professionals |
| Home Office 2019[58] | UK | National government | FGM |
| Royal College of Midwives 2013[59] | UK | NHS<br>Royal Colleges together with trade unions and Equality Now | FGM |
| Royal College of General Practitioners 2014[60] | UK | NHS<br>Charity | Child protection (general) |
| Safeguarding Board for Northern Ireland 2018[61] | Northern Ireland Based on guidance from UK Department of Health | National government | FGM |
| Safeguarding Board for Northern Ireland 2018[62] | Northern Ireland | National government | Neglect |

| | | | |
|---|---|---|---|
| All Wales Child Protection Procedures Review Group 2013[63] | Wales | National government<br>Appears to be Welsh Government document | Sexual abuse/exploitation |
| Public Health England 2018[64] | England | National government<br>Provenance unclear but PHE appears to be involved | Other harm/abuse |
| Department of Education 2018 [65] | UK | National government<br>HM Government | Child protection (general) |

## Cultural/organisational studies

Thirty-one studies included in the review were classified as cultural or organisational studies. These research studies include data (qualitative or quantitative or mixed) on the social/cultural context of intervention delivery within an organisation or across organisations e.g. differences between different organisations that are required to work together to deliver the intervention. The included studies were published from 2004-2019, it is important to be aware that older studies might not reflect current practice. The largest number of studies, 16 considered the role of different professional groups in child protection, 14, researched multi-agency working studies and 5 studies focussed on the use of data.

### Multi-agency/Inter-professional working

Thirteen of the included cultural/organisational studies researched multi-agency working [66-78].Additionally, one study on inter-professional working within a trust is discussed in this theme [79], study characteristics are provided in Table 4.

The following three studies investigated multi-agency working between professionals in social work, health and education. A qualitative study [66] investigated multi-agency working in five multi-disciplinary teams that included social workers, professionals from health, education, probation and youth work and nursery nurses. Key themes that the study identified were the impact of co-location on learning and information sharing, the impact of joint working on professional identity and team members' understanding of the problems that children and their families experience. The five teams had developed effective methods for working together and addressed problems creatively while developing common values. Effective strategies found for multi-disciplinary teams were likely to combine inter-agency structural and internal team specific actions. The professionals involved in the study were looking for new ways to work together even when they face ongoing problems demonstrating their adaptability and commitment to working together as multi-disciplinary teams. Another qualitative study [68] reviewed the work of staff from the NHS, the Education Department, Social Workers and various adult-orientated services that were members of the core groups working under the jurisdiction of the Area Child Protection Committee in a Northern area of England.

Table 4: Study characteristics of multi-agency working studies

| Reference | Title | Setting | Data type | Participants |
|---|---|---|---|---|
| Frost 2007[66] | Joining up children's services: safeguarding children in multi-disciplinary teams | Health and social care | Qualitative | Professionals involved in study<br>Integrated team (health and social care)<br>Five MDTs took part.<br>Team members included social workers, health, education, nursery nurses, probation and youth work professionals.<br>Children/young people involved in study<br>Not applicable |
| Garrett 2004[67] | Talking child protection: the police and social workers 'working together' | Social care<br>Three Child Protection Units (CPUs) comprising police and social workers | Qualitative | Professionals involved in study<br>Social worker<br>Seven individuals from two CPUs |

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|---|---|---|---|---|
| | | | | Children/young people involved in study<br>Not applicable |
| Harlow 2006[68] | Safeguarding children: challenges to the effective operation of core groups | Social care | Qualitative | Professionals involved in study<br>Multiple groups<br>Members of 'core groups' including staff from the NHS, the Education Department and various adult-orientated services as well as social workers.<br>Children/young people involved in study<br>Not applicable |
| Hood 2017[69] | Collaborating across the threshold: The development of interprofessional expertise | Health and social care | Qualitative | Professionals involved in study<br>Multiple groups<br>Eighteen participants |

| | | | | |
|---|---|---|---|---|
| | in child safeguarding | | | comprising six from social work, six from nursing and six from education (three pre- and three post-qualification in each group)<br>Children/young people involved in study<br>Not applicable |
| Horwath 2011[70] | Effective inter-agency collaboration to safeguard children: Rising to the challenge through collective development | Other/not applicable<br>Local Safeguarding Children Boards | Quantitative | Professionals involved in study<br>Managers<br>Senior managers who are members of safeguarding partnerships<br>Children/young people involved in study<br>Unclear/not reported/not applicable<br>Not applicable |
| Lewis 2015 [71] | Working together to | | Mixed | Professionals involved in |

| | | | | |
|---|---|---|---|---|
| | identify child maltreatment: social work and acute healthcare | Health and social care<br>Acute trust paediatricians and local authority services | | study<br>Multiple groups<br>Nurses, midwives, or other staff that had lead responsibility within the trust for safeguarding.<br>Children/young people involved in study<br>Unclear/not reported/not applicable |
| Machura 2016 [72] | Inter- and Intra-Agency Co-Operation in Safeguarding Children: A Staff Survey | Social care<br>Employers of agencies associated with the Local Safeguarding Children Board in 2 counties of North Wales | Mixed | Professionals involved in study<br>Multiple groups<br>Children/young people involved in study<br>All ages |
| Moran 2006 [73] | Multi-agency working: Implications for an early-intervention social work team | Health and social care<br>Multi-agency working in an early intervention support team | Qualitative | Professionals involved in study<br>Social worker<br>Children/young people |

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| | | | | involved in study<br>All ages |
| Parton 2006 [74] | 'Every Child Matters': The shift to prevention whilst strengthening protection in children's services in England | Health and social care | Mixed | Professionals involved in study<br>Multiple groups<br>Paper discusses services provided by a wide range of professionals and agencies.<br>Children/young people involved in study<br>Unclear/not reported/not applicable<br>No direct involvement of children or young people, although specific cases of abuse are mentioned in the text. |
| Russell 2004 [76] | Child physical abuse: health professionals' | Health care | Mixed | Professionals involved in study |

| | | | | |
|---|---|---|---|---|
| | perceptions, diagnosis and responses | | | Multiple groups<br>Doctors, dentists, nurses and health visitors<br>Children/young people involved in study<br>Unclear/not reported/not applicable<br>Not applicable |
| Skinner 2007[77] | Changing structures: necessary but not sufficient | Health and social care<br>Scottish Child Protection Committee | Mixed | Professionals involved in study<br>Multiple groups<br>Committee members include representatives from social work and education, the local NHS Board (child protection nurse, consultant paediatrician, general practitioner, consultant psychiatrist and others) and other organisations. |

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|---|---|---|---|---|
| | | | | Children/young people involved in study<br>Unclear/not reported/not applicable<br>Not applicable |
| Social Care Institute for Excellence 2013[78] | Partnership working in child protection: improving liaison between acute paediatric and child protection services | Health and social care<br>Hospital paediatric and local authority child protection services in England | Mixed | Professionals involved in study<br>Multiple groups<br>Multiple groups of health and social care professionals were involved in an online survey, interviews and providing case studies<br>Children/young people involved in study<br>Unclear/not reported/not applicable<br>Not applicable |

| | | | | |
|---|---|---|---|---|
| White 2015[79] | Improving practice in safeguarding at the interface between hospital services and children's social care : a mixed-methods case study | Health care<br>Two NHS hospital trusts (one primary site). | Mixed | Professionals involved in study<br>Multiple groups<br>Professionals interviewed included consultants, nurses, midwives and administrative staff.<br>Children/young people involved in study<br>Not applicable |

Three challenges of multi-agency working were identified inter-agency co-ordination, inter-professional relationships and partnerships and children and their families. Potential changes to policy and organisation could improve the support for social workers and other professionals working within child protection. A recent qualitative study [69] researched inter-professional working with staff from social work, nursing and education. The study found their expertise in inter-professional collaboration was linked to two overarching themes professional understanding of their collaborative practice and how their approaches to managing relationships. The threshold between statutory and non-statutory services influences collaborative practice and the relationship between practitioners and parents mediated collaborative activity.

Three studies researched multi-agency working within Local Safeguarding Children Boards. One paper [70] examined strategic collaboration through the piloting of a self-assessment and improvement tool that was developed and piloted in seven Local Safeguarding Children Boards within Wales within senior manager members. The study found that members could demonstrate that their safeguarding partnerships actually had many of the conditions necessary for effective partnerships without a clear idea of how this made a difference to the children they work with. Local Safeguarding Children Boards that piloted the tool felt that it gave a framework and evidence base that could support the collective development of the board and that the practice of analysing issues collectively could lead to shared understanding of the problems and ownership of solutions developed. The paper concluded that to engage in strategic collaborations for safeguarding that are effective members need to consider three key aspects; the context that collaboration occurs, awareness of conditions of effective collaboration and their connections and the true complexity of the area and agenda of safeguarding. A mixed method study [71], published in 2015, comprised a survey of senior practitioners in acute trusts and qualitative case studies of senior practitioners in local authority and acute trusts. The study consider triage systems for child protection. The study found that joint working requires a shared vision and values, investment and a commitment to working collaboratively from organisations and practitioners. Another mixed methods study [72] surveyed employers of agencies associated with the Local Safeguarding Children Boards in 2 counties in Wales on working culture and local arrangements for inter-agency working. This study found inter-agency cooperation to be directly related to different organisations having the same or similar priorities, use of common terminology and standard processes to

resolve conflict between partner agencies, fair treatment of staff and appropriate administrative arrangements for child protection cases within the particular agency. Local Safeguarding Children Boards and their member agencies all need to work together to promote co-operation.

Additionally, one research paper [77] studied the functioning of the Scottish Child Protection Committee. Some aspects of the committee's work were very effective and highly developed for example, guidelines and multi-agency training while links with practice and the management of information systems were poor. The study authors attributed their findings to aspects of the committee such as size, coverage of three local authority areas and its patterns of working. The study found that improvements to the effectiveness of the committee require more attention to issues of authority trust and negotiation among their members.

An evaluation [73] of multi-agency working within an early intervention support team included qualitative interviews and focus groups with managers and front-line workers in the team. Challenges to multi-agency working included professional status and identity and differences in the working approaches of the different partner agencies. Best practice for multi-agency working include formal and informal conversations for workers, sufficient financial support for service development and clear protocols with procedures for negotiating and reviewing them. Benefits from multi-agency working were better communication and respect between partner agencies, enhanced understanding of the different thresholds for child protection in different partner agencies and fast-track referrals.

A small qualitative study [67] published in 2004 interviewed social workers and police officers working together within three child protection units. Comments from the respondents identified tensions in joint working and a tendency of police officers to see themselves as leading the investigations. There were significant issues related to recruitment and selection in joint units and a blurring of the professional role of social workers within joint child protection units. Further review of joint working between social workers and police officers would be useful. The creation of new social work degrees will provide an opportunity to ensure that policing and other disciplines are covered and the social process that underpin models of joint working.

Multiple-agency working between emergency departments within acute trusts and local authority services was investigated by the Social Care Institute for Excellence [78]. The report

summarises findings on staffing arrangements, identifying possible child maltreatment, referral processes, response and subsequent work and building and supporting joint working.

Multi-disciplinary working within two NHS hospital trusts was investigated by White and colleagues [79]. Consultants, midwives and administrative staff were interviewed about a range of interventions introduced to enhance safeguarding. The findings from this study suggest that systems that enhance communication are needed as well as methods for sharing information.

A literature-based discussion [74] of 'Every Child Matters' and the Children Act 2004 for the organisation of children services in England. The changes introduced by these documents represent a fundamental change in the relationship between the state, professionals and children and their families. Resources that are available for services might be insufficient to meet the challenges of the new early intervention approach.

This group of studies demonstrate that multi-agency within the complex area of safeguarding can be difficult and requires commitment and adaptability from professionals within the agencies. Challenges for multi-agency working identified in these studies included inter-agency co-ordination, inter-professional relationships and partnerships and children and their families, professional status and identity and differences in the working approaches of the different partner agencies. Best practice identified for multi-agency working included; commitment from organisations and practitioners to working together, developing a shared vision, common values, use of common terminal, inter-agency structural and internal team specific actions, sufficient financial support for service development, clear protocols with procedures for negotiating and reviewing them, standard processes to resolve conflict between partner agencies, professionals in the different agencies having a understanding of their collaborative practice and the roles of the different professionals, formal and informal conversations for workers.

### Professional role

Sixteen of the included studies considered the professional role of a professional group or multiple professional groups in child protection [72, 73, 75, 76, 80-91]. Table 5 provides the study characteristics.

Table 5: Study characteristics of professional role studies

| Reference | Title | Setting | Data type | Participants |
|---|---|---|---|---|
| Bernard 2019[80] | Recognizing and addressing child neglect in affluent families | Social care | Qualitative | Professionals involved in study<br>Sample included front line social workers and managers<br>Children/young people involved in study<br>Not applicable |
| Bradbury-Jones 2019 [81] | "I keep hearing reports on the news that it's a real problem at the moment": Public health nurses' understandings of sexting practices among young people | Health care | Qualitative | Professionals involved in study<br>Community nurse<br>Public health nurses<br>Children/young people involved in study<br>Adolescent/young adult |
| Brady 2018[82] | UK Paramedics Confidence in Identifying Child Sexual Abuse: A Mixed-Methods Investigation | Health care<br>Large UK ambulance service | Mixed | Professionals involved in study<br>Paramedic<br>n=276 for online survey and 25 for focus groups<br>Children/young people involved in study<br>Not applicable |
| Clarke 2019[83] | Experience of and barriers to reporting child safeguarding concerns among general dental | Health care | Quantitative | Professionals involved in study<br>Dentist<br>Children/young people |

| | | | | |
|---|---|---|---|---|
| | practitioners across Greater Manchester | | | involved in study<br><br>Not applicable |
| Crisp 2004[84] | Child protection and public health: nurses' responsibilities | Health care<br>Community nursing | Qualitative | Professionals involved in study<br>Community nurse<br>Health visitor<br>Children/young people involved in study<br>Unclear/not reported/not applicable<br>Not applicable |
| Franklin 2017[85] | Recognising and responding to young people with learning disabilities who experience, or are at risk of, child sexual exploitation in the UK | Health and social care | Mixed | Professionals involved in study<br>Multiple groups<br>34 key stakeholders working in CSE and/or LD from across the UK, including health and social care<br>Children/young people involved in study<br>Adolescent/young adult<br>27 young people aged 12 to 23 (19 aged under 18) with LD who had experienced or were at risk of sexual exploitation |
| Horwath 2015[86] | Child visibility in cases of | Social care | Qualitative | Professionals involved in |

| | | | | |
|---|---|---|---|---|
| | chronic neglect: Implications for social work practice | | | study<br>Multiple groups<br>Interviews involved chairs of child protection conferences (n = 6) and social workers (n = 12). Focus group participants came from a range of disciplines including education, health, probation, YOT (Youth Offending Teams) children's social services and adult services.<br>Children/young people involved in study<br>All ages<br>Case files of 21 children experiencing chronic neglect (12 boys and 9 girls aged between 3 and 16) were analysed. |
| Hynes 2010[87] | Global points of 'vulnerability': understanding processes of the trafficking of children and young people into, within and out of the UK | Social care | Qualitative | Professionals involved in study<br>Multiple groups<br>72 practitioners were involved (no further details reported)<br>Children/young people involved in study<br>All ages |

| | | | | |
|---|---|---|---|---|
| | | | | 37 case studies (no further details reported). Also a Young Persons Advisory Group provided feedback to the research team. |
| Machura 2016 [72] | Inter- and Intra-Agency Co-Operation in Safeguarding Children: A Staff Survey | Social care<br>Employers of agencies associated with the Local Safeguarding Children Board in 2 counties of North Wales | Mixed | Professionals involved in study<br>Multiple groups<br>Children/young people involved in study<br>All ages |
| Moran 2006 [73] | Multi-agency working: Implications for an early-intervention social work team | Health and social care<br>Multi-agency working in an early intervention support team | Qualitative | Professionals involved in study<br>Social worker<br>Children/young people involved in study<br>All ages |
| Olive 2016 [88] | Do you see what I see? Identification of child protection concerns by hospital staff and general dental practitioners | Health care | Mixed | Professionals involved in study<br>Multiple groups<br>Children/young people involved in study<br>All ages |
| Pearce 2006[75] | Who needs to be involved in safeguarding sexually exploited young people? | Health and social care | Qualitative | Professionals involved in study<br>Multiple groups<br>Paper discusses the need for multiple services to support sexually exploited young people. |

| | | | | |
|---|---|---|---|---|
| | | | | Children/young people involved in study<br>Adolescent/young adult<br>Three case studies reported (extracted from research involving 55 young women who experienced or were at risk of sexual exploitation). |
| Percy-Smith 2018 [92] | Stories from journeys to the edge of care : Challenges for children and family services | Social care<br>Children, Young People and Family services in 1 local authority | Qualitative | Professionals involved in study<br>Social worker<br>Children/young people involved in study<br>Adolescent/young adult<br>Research aimed to included young people aged 11-18 but included participants were actually aged 14-18. |
| Russell 2004[76] | Child physical abuse: health professionals' perceptions, diagnosis and responses | Health care | Mixed | Professionals involved in study<br>Multiple groups<br>Doctors, dentists, nurses and health visitors<br>Children/young people involved in study<br>Unclear/not reported/not applicable<br>Not applicable |

| | | | | |
|---|---|---|---|---|
| Tweedlie 2019[91] | Adult student nurses' experiences of encountering perceived child abuse or neglect during their community placement: Implications for nurse education | Health care<br>Community nursing | Qualitative | Professionals involved in study<br>Community nurse<br>Adult nursing students doing community placements<br>Children/young people involved in study<br>Unclear/not reported/not applicable<br>Not applicable |
| Woodman 2013[90] | Responses to concerns about child maltreatment: a qualitative study of GPs in England | Health care<br>General practice | Qualitative | Professionals involved in study<br>GP<br>Community nurse<br>Health visitor<br>Children/young people involved in study<br>Not applicable |

Crisp and colleagues [84] found that community nurses and health visitors working at a Scottish NHS Trust did not agree about the role of nurses in child protection, particularly with respect to the extent to which nurses should actively seek to detect cases of child abuse. A role in identification and detection was not easily accepted by many of the practitioners interviewed and some saw this role as a change from their more traditional role of supporting families, as well as being potentially in conflict with some public health responsibilities. Despite the views expressed by some of the nurses in the study, the authors concluded that there is actually no sharp divide between child protection work and public health interventions and that there is a role in child protection for many nurses other than health visitors. Doctors, dentists, nurses and health visitors working in primary care in Northern Ireland were surveyed for their involvement in recognising and reporting abuse [76]. The majority (58%) of the respondents had seen a case or cases of suspected child abuse and 47% had reported a case. Professionals groups varied on their perceived ability to recognise and willingness to report suspected abuse. Barriers identified in the study to reporting abuse were: fear of misdiagnosis; professional uncertainty in reporting abuse; professional challenges to reporting abuse; and a need for multidisciplinary education and training. The study concludes that the process of recognising and reporting abuse could be improved by providing multi-professional and inter-agency training, supporting primary health professionals in practice, and appropriate higher education programmes. GP's, community nurses and health visitors were interviewed to find out about their experiences of families that had prompted their concerns about child maltreatment. [90]. The main concerns raised were neglect and emotional abuse. GPs identified seven possible responses to maltreatment-related concerns that were directed to whole families, parents and children. GPs reported referring cases to other services in addition to recording their concerns. A recent survey study [82] found that paramedics that responded reported low levels of confidence in recognising all areas of sexual abuse, although many reported being uncertain. Paramedics' lack of confidence was explained by the following themes, lack of exposure, hidden abuse, lack of physical examination, geographical focus; non-physical signs of abuse, and lack of training. The study found that the most significant contributor to the lack of confidence among paramedics in detecting signs of abuse was insufficient knowledge. The authors conclude that the findings suggest a lack of sufficient training and further research could beneficially consider evaluating the content of current training and how it is delivered. A study of student nurses [91] found that participants underwent a process of transformational learning as a result of experiencing cases of perceived child abuse and neglect with their understanding of the role

of the adult nurse changing and they accepted that they had a role in safeguarding children. There is a need to ensure that students on adult nursing programmes recognise their role in protecting children for which they require more effective preparation and support.

Three of the studies investigated the role of professionals in relation to the specific abuse of sexual exploitation [75, 81, 85]. A recent small qualitative study [81] interviewed public health nurses on the topic of sexting, which has the potential to lead to sexual exploitation. All of the nurses interviewed believed that they had a role in harm reduction associated with sexting and that to fulfil their role effectively further education/training and support was required. A mixed-methods study [85] investigated professional stakeholders working within child sexual exploitation and learning disabilities within local authorities across the UK and young people that had used these services. This study found that children and young people with learning disabilities had an increased risk of sexual exploitation but that they are often not referred to the appropriate services. Professionals interviewed that had expertise in child protection were generally unaware of specific issues related to children and young people learning disabilities and professionals working within learning disabilities services sometimes overlooked the risk of sexual exploitation which were barriers to joint working in this area. Education, training and awareness raising amongst young people, their families and professionals are needed to improve services provided to this population and to enable full implementation of national guidance and policies, which was found to be variable across the UK. An older qualitative discussion paper [75] examined three case studies reported from research involving young women that had experiences or were at risk of sexual exploitation. The case studies illustrated the different experiences of the young women. Sexually exploited young women need support from a range of services and to provide appropriate support the service providers need to recognise and understand sexual exploitation which is a potential educational/training need. In dealing with sexually exploited young people services need to see them as active in the process not just victims and help them to make choices about their lives. These three studies demonstrate that sexual exploitation is an area where further training and support is required for practitioners.

Additionally, a qualitative study [87] interviewed practitioners about trafficking. Professionals caring for children and young people often viewed trafficking as a one-off 'event'. However, examination of cases suggested that trafficking is better understood as a process without a clear beginning or end. Points where children were particularly vulnerable were identified

before and after their arrival in the UK. Viewing trafficking as a broader sociological process rather than an event allows a greater understanding of the environmental backgrounds of individual children, including the situation in their country of origin and their migration pathways. It is suggested that this may lead to an enhanced ability for practitioners to identify children who may have been trafficked

Two of the included cultural/organisational studies investigated dental services [83, 88]. A small qualitative survey [83] investigated a convenience sample of general dental practices in Manchester to find out the safeguarding training and knowledge of their dentists, any previous safeguarding referrals and any barriers to referral of suspected child abuse or neglect. This study, which had a low response rate, found that over half of the respondents (58%) had received safeguarding training as an undergraduate and nearly all (83%) as a postgraduate. Most of the respondents (81%) communicated a need for further training and support in the area of safeguarding. More than half (58%) of the respondents had encountered a case of suspected abuse or neglect but only 28% had actually completed a referral, barriers to reporting suspected cases were fear of further violence to the child involved, uncertainty about their diagnosis and lack of confidence in their suspicions. Another small study [88] used a mixed-methods design to survey a convenience sample of dentists, doctors and nurses from dental practices and inpatient and outpatient health care setting in Cardiff. The survey used fictional vignettes reflective of dental and child protection issues the professionals could encounter to explore the actions they would take. The doctors and nurses were better than the dentists were at selecting the most appropriate child protection actions. The study conclude that doctors and nurses working within paediatrics need training in examining a child's dental health and when to refer to a dentist and dentists need training on recognising potential cases of child abuse or neglect and the referral pathways. To help ensure that professionals provide the same care joint training courses for dentists and paediatric staff would ensure that the professionals have similar knowledge of child protection and referral pathways. Both of the recent studies that researched dental services identified the need for further education/training for dentists in safeguarding and paediatric doctors and nurses in assessing a child's dental health.

A qualitative study [86] involving chairs of child protection conferences and social workers, held focus group with participants from a range of disciplines including education, health, probation, YOT (Youth Offending Teams) children's social services and adult services explored the emerging themes with social workers obtained the perspectives of other

professionals involved in child protection. Four themes were associated with a lack of child centred practice by social workers: generalised assessment and not seeing the child as a unique individual; superficial consideration of the child's wishes and feelings; lack of awareness of the different needs of children in a family; and considering parenting in isolation from improved outcomes for the child. Social workers can improve their awareness of the needs of children experiencing neglect by changing their view of the 'neglected child' to one that takes into account the unique experiences of every neglected child. An exploratory qualitative study [80] was performed with social workers and managers from 12 English local authorities around identifying child neglect. Findings suggested that neglect is challenging to identify in affluent families because practitioners commonly look for indicators such as poor hygiene and living conditions, inadequate clothing and poor diet while most cases in affluent families involved emotional neglect. Study participants described how that they had to deal with complex power relationships with parents who tried to use their class privileges to resist the help and interventions from social workers. Support from managers helped social workers to keep the focus on the child without being distracted by the complaints process.

A qualitative study [89] to better understand the needs and experiences of young people (11-17) and their families that have been involved in the care systems and their reflections and experiences of the services. The young people's involvement with social services occurred for a number of reasons but the researchers found similar issues from their involvement with services; the young people didn't feel that they were listened to, disruption arising from emotional or psychological issues and no early identification of their problems or support. Professionals were challenged by the study findings and their regular professional reflection could help them as a professional and their organisations to develop by being flexible and adaptive. The study concluded that social workers need to ensure that children are listened to and there is a need for rethinking of child protection to family centred practice. Children and family services need to be learning systems that are flexible and adaptive.

A mixed methods study [72] on working culture and local arrangements for inter-agency working found that the balance between professional autonomy and responsibility of social worker and administrative control from their managers is delicate and found the right balance is challenging. A qualitative evaluation [73] of multi-agency working within an early intervention support found that challenges to multi-agency working included professional status and identity.

These studies have demonstrated that professionals are unsure about their role in child protection and lack confidence in their ability to perform this role effectively. Many of the studies conclude that there is a need for further education and training and that multi-professional and inter-agency training could potentially be useful. Additionally, the importance of child centred practice within this complex area was highlighted.

### Use of data/frameworks

Five studies examined the use of date and frameworks within child protection [93-97], study characteristics are provided in Table 6

Two studies analysed routinely collected data. Data recorded about hospital admissions for children under 5 years old from 2007 to 2009 related to child maltreatment was analysed [93]. Codes related to maltreatment identify children likely to meet thresholds for suspecting or considering maltreatment and taking further action, as recommended by the National Institute of Health and Care Excellence. A cohort study [94] analysed data from a UK primary care databases on the incidence of recorded codes for maltreatment. The analysis indicated that GPs are increasingly recording concerns about possible child maltreatment and that there is scope for increasing recording; this will have implications for resources needed to respond to concerns.

Table 6: Study characteristics of use of data studies

| Reference | Title | Setting | Data type | Participants |
|---|---|---|---|---|
| Gonzalez-Izquierdo 2010[93] | Variation in recording of child maltreatment in administrative records of hospital admissions for injury in England, 1997-2009 | Health care<br>Hospital admissions in England | Quantitative | Professionals involved in study<br>Multiple groups<br>Staff involved in recording data about hospital admissions related to child maltreatment<br><br>Children/young people involved in study<br>Pre-school<br>children aged between 1 week and 5 years admitted to hospitals in England between with acute injury between April 1997 and February 2009. |
| Horwath 2011[96] | See the Practitioner, See the Child: The Framework for the Assessment of Children in Need and their Families Ten Years On | Social care | Qualitative | Professionals involved in study<br>Multiple groups<br>Social workers and 'operational staff from a range of disciplines' (n = 62)<br><br>Children/young people involved in study<br>Not applicable |

| | | | | |
|---|---|---|---|---|
| Lushey 2018 [97] | Assessing Parental Capacity when there are Concerns about an Unborn Child: Pre-Birth Assessment Guidance and Practice in England | Social care | Mixed | Professionals involved in study<br>Social worker<br><br>Children/young people involved in study<br>Pre-school |
| Melling 2012 [95] | Penetrating assaults in children: often non-fatal near-miss events with opportunities for prevention in the UK | Health care<br>Emergency department | Mixed | Professionals involved in study<br>Multiple groups<br><br>Children/young people involved in study<br>All ages <16 |
| Woodman 2012[94] | Variation in recorded child maltreatment concerns in UK primary care records: a cohort study using The Health Improvement Network (THIN) database | Health care<br>General practice | Quantitative | Professionals involved in study<br>GP<br><br>Children/young people involved in study<br>Not applicable |

A mixed-methods study [95] analysed data from children under 16 years attending an emergency department for incidence of violent injury from 2003-2008. The rates of gun and stab assault did not increase or decrease and injuries were generally minor and children did not need to be admitted. The study found that adolescent boys from deprived areas appeared to be at most risk, attacks were more common at weekends and in public spaces outside school and home and that the paediatric emergency department were not using educational interventions for violent injury prevention. While most of the injuries presenting to emergency department were minor the rare tragic cases indicate that the minor cases really represent concerning near misses. In the UK the use of interventions that have been shown to reduce violent injury and re-injury in specific high-risk groups could potentially be pursued for patient safety and child protection purposes.

Horwath and colleagues [96] carried out focus groups with front-line professionals who use the Framework for the Assessment of Children in Need and their Families. The framework was enthusiastically received and used widely in practice. However, participants reported that maintaining a focus on the child does not occur routinely in practice, reasons for this included lack of training and guidance, a focus on managing risk, organisational contexts that emphasise targets and timescales, a tendency for assessments to become formalistic, some groups of children (e.g. those with disabilities) becoming marginalised and practitioners struggled to establish good relationships with children and families. The framework could be very useful and its optimal use requires attention to the organisational context in which it is delivered and the needs of the staff who use it.

One study [97] investigated local safeguarding guidance on and social workers use of pre-birth assessments. The local guidance was generally more detailed than the national guidance but rarely considered legal and ethical issues. Four themes emerged from interviews with 22 practitioners: adequacy of the guidance, complexities of assessment, timing of assessment and the use of standardised assessment tools. Generally, the participants felt that guidance on pre-birth assessment was insufficient and that they did not provide practitioners with information about the assessment process and appropriate tools that could be used in the assessment with only a few of the practitioners reporting that they made use of standardised tools in assessments. There was a feeling that that pre-birth assessments were lower priority

than infant/older children cases which could lead to delays in providing parental support. The study found that the current guidance and practice around pre-birth assessment is inadequate and that it needs to be improved, in particular what needs to be assessed and when and how tools can be used by practitioners alongside professional judgement.

### Training

Studies from other themes highlighted the need for education and training in safeguarding including [81, 82, 85, 88, 97 76, 91]. These studies range in date from 2004-2019 with more recent studies indicating that there is still a need for safeguarding training. Training is covered in more detail under 'initiatives' below.

## Initiatives

Sixty-nine papers described initiatives (generally interventions characterised by a finite project life cycle and a summative evaluation) to raise awareness of safeguarding issues among health and care professionals. The majority of papers (54) were classified as empirical studies. The largest groups of studies dealt with raising awareness through training (including identification of training needs; 32) and development of services to improve safeguarding processes (30 papers). A small but important group of papers related to improving awareness of safeguarding by better use of data (five papers). Just two initiatives were identified outside these three broad categories[98, 99]; see below under 'other initiatives'.

## Mapping review

### *Training*

The studies of training fell into two groups: studies describing and evaluating training initiatives (16 papers) and those that evaluated knowledge/training needs and in most cases proposed initiatives to improve awareness and decision-making (also 16 papers). One pair of papers reported the development of training for GPs on links between domestic violence and child safeguarding[100]followed by a pilot evaluation of the programme[101].

The studies that evaluated training initiatives (Table 7) took place in a variety of settings, including hospitals, general practice/primary care and the community. Most studies involved mixed groups of professionals drawn from healthcare, social care or both. The format of the training varied but courses lasting one or a few days were most common. One exception was the paper by Cowley et al. reporting on an initiative to raise awareness of child protection by conducting rigorous systematic reviews and making the results available in accessible formats[102]. Components of the training initiatives are discussed in more detail below (see 'Component analysis').

Almost all of these papers reported positive results in terms of participants' reported improvements in knowledge, confidence, attitudes and similar outcomes. However, the evidence base was weak overall. Most studies used a before/after design with no control

group or a cross-sectional analysis of participant feedback. Only a few studies followed up with participants after the end of the initiative[101, 103-107] and one of these reported a low response rate, which would be expected to be a common problem with this type of study[103]. One study reported indications of changes in practice by some clinicians following training[101]. None of the studies investigated the costs of training initiatives in any detail, although Lexton et al. investigated working with professional actors and concluded that working with actors can be rewarding in spite of the costs involved[108].

Table 8 briefly summarises the studies describing training needs. These were published between 2004 (earliest date for inclusion in the review) and 2018. Identified needs range from basic training to specialised training to allow professionals to fulfil specific roles[109] or to improve their understanding of advances in technology that may raise new safeguarding issues[110]. However, the most frequently expressed need is for training on detection of specific forms of abuse such as FGM[111, 112] or abusive head trauma[113].

In summary, implementation and evaluation of training initiatives has taken place alongside a continued expression of need for further training. Many of the published evaluations are of low quality and cover one-off interventions with limited or no follow-up. By contrast, guidelines emphasise the need for training to be regularly reinforced as well as evaluated[114] .

Table7: summary of training evaluations

| Study | Setting | Professionals involved | Type of initiative | Type of evaluation | Follow-up | Outcomes related to awareness |
|---|---|---|---|---|---|---|
| Baverstock 2008[115] | Hospital | Multiple<br>Clinical and non-clinical staff | Audit of training and knowledge | Before/after | No | Increased knowledge after training |
| Brewer 2012[116] | Hospital | Multiple<br>All staff | Child Protection Week | Before/after | No | Increased awareness and training uptake after Child Protection week |
| Cowley 2013[102] | Health and social care | Multiple | Distribution of systematic reviews and related products | Cross-sectional | No | Availability of high quality synthesised evidence |
| Hackett 2013[117] | Health and social care | Multiple<br>Social workers and health professionals | Interagency training | Before/after | No | Increased confidence/knowledge in dealing with young people showing harmful sexual behaviour |
| Harris 2011[118] | GDP | Dentist | Child protection learning resource | Before/after (questionnaire) | No | Self-reported increased knowledge |
| Hudson 2018[119] | Community | Multiple<br>No details | Education programmes on | Before/after | No | Self-reported benefits from educational programme |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | reported | CSA | | | |
| Jackson 2017[104] | GP training | GP trainees | Skills based safeguarding training | Cross-sectional | Yes (on sustainability of programme) | Sustainable training programme |
| Carpenter 2011 [103] | Health/SC | Multiple Mainly social workers and nurses | Training in parental mental illness and safeguarding | Before/after (questionnaire) | 3 months but results not reported due to low response rate | Effect variable by outcome |
| Scourfield 2012[105] | Social care | Social workers | Team training on engaging with fathers in safeguarding | Before/after | 2 months | Increased self-efficacy and changed attitudes |
| Keys 2005[120] | Primary care | Multiple Primary health care teams | Child protection training | Cross-sectional (evaluation forms and internal audit) | No | Internal audit reported increased knowledge |
| Lewis 2017[101] | General practice | General practice clinicians | Training on safeguarding and domestic violence | Before/after (mixed methods) | 3 months | Pilot training 'feasible and acceptable' |
| Lexton 2005[108] | Health and social care | Various | Interagency training involving professional actors | Cross-sectional (participant evaluations) | No | Training with actors can be rewarding |

| | | | | | | |
|---|---|---|---|---|---|---|
| Patsios 2010[121] | LSCB | Multiple Managers and training co-ordinators | Interagency training | Realist evaluation | No | Changes observed at organisation level. Interagency training needs to take account of context |
| Smikle 2017[106] | Hospital | Nurses | Training in safeguarding supervision | Cross-sectional | 9 months after completing training | Training for safeguarding supervision feasible |
| Soldani 2008[107] | Dental hospital | Dentists and other dental health professionals | Basic child protection training | Before/after | 6 weeks | Knowledge generally improved after training |
| Watkin 2009[122] | Health and social care | Interagency child protection teams | Interprofessional learning programme | Before/after | No | Improvements in team climate inventory, seen as positive experience. Importance of outside facilitation |

Table 8: summary of studies investigating training needs

| **Study** | **Setting** | **Professionals involved** | **Summary of expressed needs** |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Cairns 2004, 2005[123, 124] | GDP | Dentists | Limited training/knowledge of child protection, more needed |
| Clark 2018[110] | Community | Nurses | Public health nurses need more understanding of technology to advise on 'sexting' |
| Cowley 2018[113] | Health and Social care | Various | Need for interprofessional training on head trauma |
| Davis 2006[125] | Hospital | Radiographer | Need training on signs of possible abuse and referral |
| Holmes 2017[111] | Community | GPs | Culturally sensitive education on FGM |
| Hosdurga 2010[126] | Hospital | Paediatricians | Doctors qualified overseas may lack child protection training |
| Kwhali 2016[127] | Social care | Social workers | Identified risk that required training may be neglected |
| Lazenbatt 2006[128] | Primary care | Various | Training needed to overcome barriers to reporting |
| Leung 2009[109] | Hospital | Radiologists | Training needed for radiologists to appear as expert witnesses |
| Lewin 2007[129] | Community | Health visitors | Value of consensus for detecting neglect |
| Lewington 2010[130] | Hospital | Psychiatrists | Many had not attended child protection training, some thought it not relevant. |
| Oakley 2017[131] | Community | Various | Need for training on child abuse linked to faith or belief (CALFB) |
| Relph 2013[112] | Hospital | Paediatricians<br>Nurses | Knowledge of FGM increasing but still considered insufficient |
| Shabde 2006[114 2558] | Hospital | Paediatricians | Training needs reinforcement and evaluation |
| Szilassy 2017[100] | Primary care | GP | Need for more training in engaging with domestic abuse |

### *Service development*

The existence of appropriate services to meet safeguarding needs reflects the awareness of health and social care commissioners and other decision-makers. The 31 included papers in this group were divided almost equally between health settings (11 papers), social care settings (10) and services integrated across both systems (10).

Table 9 summarises the papers dealing primarily with the NHS. Two included papers provide overviews of safeguarding in the NHS[132] and of therapeutic services for children who have experienced sexual abuse[133]. Both studies identified areas for improvement in awareness and safeguarding practice. Similarly, Appleton et al.'s interviews with child protection nurses identified pressures in primary care that could reduce the ability of the health system to respond to child protection needs[134]. These studies were published in 2009 to 2012 so may not fully reflect the current situation. Tompsett et al. noted the existence of conflicts around involvement of GPs in child protection and safeguarding, some GPs seeing their role as primarily referral to social services while other stakeholders anticipated a higher degree of involvement[135].

Other papers in this group cover specific initiatives at the level of primary care or in hospital settings. Specialist health visitors[136] and dentists performing a comprehensive oral assessment[137] have both been shown to have the potential to contribute to improved awareness and assessment of child protection needs. In the hospital setting, a nurse child protection co-ordinator improved the referral process[138] and an outpatient clinic for children with suspected FGM was established in response to awareness of this form of abuse in some communities[139, 140]. Finally, Kaye et al. developed a process for increasing awareness of risks associated with parental mental illness and ensuring that children of people presenting with mental illness are assessed for risk and safeguarded as necessary[141].

Overall, the evidence suggests that NHS professionals have developed a diverse range of interventions to improve awareness of safeguarding at the local level against a background of challenges to improvement at the national (England, Scotland or UK) level

Ten papers (Table 10) focused on initiatives classified as social care (mainly services provided by local authorities or the voluntary sector rather than the NHS). These papers described and/or evaluated a range of initiatives including methods[142-144], service models[145, 146] and initiatives aimed at safeguarding specific groups such as trafficked children or those in local authority care[147-151]. The papers mainly involved cross-sectional evaluations based on qualitative interviews and/or document reviews. Some initiatives appeared promising[143, 145, 146] but problems were also identified, particularly difficulties in agencies with different priorities and world views working together to improve safeguarding[147, 150].

The group of ten papers that spanned health and social care (Table 11) identified similar themes to the social care papers. Promising initiatives to promote awareness included some local authority partnership child sexual exploitation services (though other related services worked less well) [152]; joint protocols between adult mental health and children's social services[153]; and a paediatric dentistry liaison service[154] based in a hospital but working between community and social services. In contrast to these positive local examples, studies with more of a national focus often identified deficiencies in the availability of services and/or training[155, 156] or variations in the delivery of a specific intervention[157]. In one study, integrated working between health and social services was hampered by a lack of compatible record systems[158].

As before, most of the evaluations in this group were cross-sectional and based on interviews or survey responses rather than hard data. An exception was the study by Devine et al. who used long-term data from 1989 onwards to analyse trends in assessment and referral[159]. Spencer et al. were the only authors to include a comparison group, although their study only included routine data on a small number of patients[154].

Table 9: summary of service initiatives mainly in health settings

| Study | Setting | Professionals involved | Type of service | Type of evaluation | Outcomes related to awareness |
|---|---|---|---|---|---|
| Care Quality Commission 2009[132] | Hospital | Multiple groups | Services provided by NHS Trusts | Cross-sectional | Trusts should review safeguarding arrangements and commissioning organisations need to ensure effective safeguarding in general practices |
| Allnock 2012[133] | Hospital and community | Multiple groups | Therapeutic services for children who have experienced sexual abuse | Cross-sectional | Significant shortfall in services relative to demand. Identifies need for relevant professionals to be trained to identify vulnerable children |
| Appleton 2012[134] | Community | Child protection nurses | Primary care child protection services | Cross-sectional | Challenges include child protection moving off primary care agenda, high threshold for referral to social services |
| Browne 2013[136] | Community | Health visitors | Family nurse partnership | Cross-sectional | Service can be made most efficient by focusing on families with known risk factors |
| Park 2015[137] | Community | Dentists | Oral assessment as part of comprehensive medical assessment | Cross-sectional | Oral assessment by a dentist can improve awareness of child protection needs |

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|---|---|---|---|---|---|
| Bajaj 2006[138] | Hospital | Specialist nurse | Liaison and discharge co-ordinator role | Before/after | Recording and analysis of outcomes can improve understanding of important factors affecting outcomes |
| Hodes 2016, 2017[139, 140] Creighton[160] | Hospital outpatient clinic | Multi-disciplinary team | Clinic for children with known or suspected FGM | Service description and case series | Availability of specialist service in response to awareness and need |
| Kaye[141] | Hospital ED | ED clinicians | Risk assessment for children of people presenting with mental health problems | Before/after (audits) | Protocol increased awareness of children potentially needing safeguarding |

Table 10: summary of initiatives focused on social care

| Study | Setting | Professionals involved | Type of service | Type of evaluation | Outcomes related to awareness |
|---|---|---|---|---|---|
| Appleton 2015[142] | Local authority | Social workers | Strengthening Families child protection conference | Before/after | Most professionals thought approach worked well but families perceived they were being judged |
| Ashley 2017[143] | City LSCB area | Social workers and others with safeguarding responsibility | FMEA (Failure Mode and Effects Analysis | Cross-sectional | FMEA was valuable for participants and generated actions to improve response |
| Firmin 2016[144] | Local authorities | Social workers | Contextual social work interventions | N/A (summary of published research) | Interventions that take account of context may improve safeguarding |
| Harris 2017[145] | Voluntary sector child sexual exploitation (CSE) services | Multiple groups Child protection professionals and CSE workers | 'Hub and spoke' model, including training for professionals | Cross-sectional | Hub and spoke model improves standards in local safeguarding by extending the reach of training and resources |
| Whiting 2008 [146] | Local authority | Multiple groups Nurses, health visitors (including | Health specialist initiative (health visitors seconded to child protection teams) | Cross-sectional | The health specialist was successful in improving communication, increasing social |

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|---|---|---|---|---|---|
| | | 'health specialists'), social workers and managers | | | workers' knowledge of child health and strengthening assessments made in social care. |
| Gupta 2010[147] | Social care system | Social workers and other practitioners | Improved recognition and safeguarding of trafficked children | Review of research and cross-sectional (interviews) | Need for improved training and deployment of staff, better interprofessional working and collection and sharing of data |
| Hurley 2015[148] | Social care system | Social workers and others working with Romanian children | International Multi Agency Assessment Framework (IMAAF), a tool to prompt professionals to consider safeguarding issues related to trafficking | Evaluation of the IMAAF was in progress at the time of the report. | IMAAF encourages agencies to work together within and between countries to safeguard trafficked children |
| Heikkila 2011[149] | Social care system (UK and other European countries) | Social workers and police | Examples of police and social workers working together, including school safety initiatives | Cross-sectional | Shows importance of networks between practitioners and multicultural skills |
| Peckover 2017[150] | Local authorities | Multiple groups Practitioners working in domestic abuse and safeguarding | Development of multiagency working in domestic abuse and child safeguarding | Cross-sectional | Need for further improvement in multiagency working to safeguard children |

| | | | | | |
|---|---|---|---|---|---|
| Pinkerton 2015[151] | Health & Social Care Trusts in Northern Ireland | Multiple groups Agencies dealing with 'looked after' children | Review of cases of 'looked after' children who had repeatedly 'gone missing' and were at risk of sexual exploitation | Cross-sectional | Improved awareness of 'going missing' as a possible indicator of sexual exploitation needing a multiagency response |

Table 11: summary of service initiatives across health and social care

| Study | Setting | Professionals involved | Type of service | Type of evaluation | Outcomes related to awareness |
|---|---|---|---|---|---|
| Care Quality Commission 2016[155] | Health and social care services in England | Multiple groups | Services for 'looked after' children | Cross-sectional | Examples of good and innovative practice but more needs to be done to identify children at risk of harm |
| Devine 2015[159, 161] | Health and social care services in England | Multiple groups | Analysis of trends in assessment and referral | Time series | Trend to increased referral but not increased detection of abuse; possible lower threshold for referral |
| Kaur 2018[152] | Five local authorities in England | Multiple groups<br>Commissioners, commissioning partners, service providers and local practitioner experts | Commissioned services to address child sexual abuse and exploitation (CSA and CSE) | Cross-sectional | Local authority partnerships are running well-developed CSE initiatives; CSA and harmful sexual behaviour should be targeted with the same rigour as CSE. Health bodies have a role in addressing all three types of abuse. |
| Haynes 2015[156] | Health and social care | Multiple groups<br>Early years practitioners | Services for children at risk of neglect | Cross-sectional (interviews, focus | Shortfalls in services identified, all practitioners have a role in |

| | | | | | |
|---|---|---|---|---|---|
| | services in England | Health visitors<br>Midwives<br>Schools nurses<br>Teachers; GPs | | groups and surveys) | identifying and providing early help for children suffering neglect |
| Daniel 2010[162] | Health and social care services in England | Multiple groups<br>Multidisciplinary groups of practitioners from all key professions working with children | Action on Neglect educational resource | Cross-sectional | Availability of support and services in response to early signs of problems will often enable parents to provide required care |
| Bunn 2013[157] | Health and social care services in England | Multiple groups<br>Multidisciplinary teams | Signs of Safety model for risk assessment and safety planning | Cross-sectional (survey and interviews) | Local authorities using the model in different ways, need for long-term evaluation of outcomes |
| Fifield 2011[158] | Health and social care in an area of NW England | Multiple groups<br>Multidisciplinary teams<br>Managers | Pilot integrated model involving safeguarding nurses | Cross-sectional (questionnaires) | Model achieved its aim but efficiency was reduced by lack of an integrated IT system |
| Webber 2013[153] | London borough: adult mental health and children's | Multiple groups<br>Social workers (52%); managers; nurses; psychiatrists; clinical | Joint protocols to support multiagency working | Cross-sectional (survey) | Practitioners perceived that the protocols had increased awareness of the risk factors for safeguarding children. |

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| | social care | psychologists; and occupational therapists | | | |
| Spencer 2019[154] | Dental hospital and local child protection services | Hospital nurse | Paediatric liaison nurse service | Case series with comparison group | Service promotes integrated multidisciplinary working and helps overcome barriers to dentistry's involvement in safeguarding children. |

Table 12: summary of initiatives involving use of data

| Study | Setting | Professionals involved | Type of initiative | Type of evaluation | Outcomes related to awareness |
|---|---|---|---|---|---|
| Arai 2015[163] | NHS in England | Multiple groups<br>Interview subjects included service managers; health visitor; safeguarding nurse; consultant paediatricians; and an administrator | Guidelines to follow up non-attendance | Cross-sectional (mapping and interviews) | Better use of non-attendance data could improve awareness of safeguarding concerns |
| McGough 2006[164] | Integrated sexual health service in Glasgow | Multidisciplinary team<br>Staff providing sexual and reproductive health service at a centre that also provides counselling, information and support services. | Recording of data from consultations with clients aged under 16 | Case series | Answers to some questions may raise awareness of child protection issues |
| McGovern 2015[165] | Eleven general practices in England | GPs | Coding to improve recording of child maltreatment concerns | Before/after (audit) | Improved recording could improve data sharing and identification of children at risk |
| Mitchell 2019[166] | Seven hospitals in East Anglia | Paediatricians | Assessment of children with fractures in the | Cross-sectional | Detection of possible abuse could be improved by |

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| | | | ED for risk of physical abuse | | reducing variation in referral to paediatric assessment |

### *Use of data*

Four included studies (Table 12) focused on initiatives involving use of routine data to improve awareness of safeguarding at the system level in health and/or social care[163-166]. Studies in primary care settings (a sexual health clinic[164] and a range of general practices[165]) suggested that it is possible to improve data collection in clinical practice to improve identification of possible safeguarding issues. The two studies conducted in hospitals revealed variation in the handling of missed appointments[163] and in procedures for referring young children with fractures for paediatric assessment[166]. Although a limited sample, these studies suggest that reduction in variation between hospitals may be a way of improving use of data that are collected routinely and improving outcomes for children experiencing or at risk of abuse

### *Other initiatives*

Only two studies reported on other initiatives[98, 99]. One was a qualitative study of reporting of possible abuse by primary healthcare professionals[98]. The other looked at how cases of child neglect are managed over time and concluded that a new approach is needed, involving collection of evidence that could be used in care proceedings if necessary[99].

## Component analysis

Twenty-two papers reporting initiatives were classified as suitable for component analysis using the TiDIER-Lite checklist: 11 evaluations of training, seven studies (eight papers) on service development and three studies on use of data.

### *Training*

Components of training interventions are summarised in Table 13. A few studies reported some details of staff delivering the intervention[101, 117, 122] while others described them simply as 'trainers'[105] or 'staff'[119]. Some authors reported how the intervention was developed[104, 118]. Content of the interventions mainly comprised taught courses lasting a few hours or days, or longer learning programmes. Most were aimed at specific groups of practitioners, sometimes drawn from different professions (e.g. health care and social care). An exception was a hospital 'child protection week' which used a variety of displays and events to raise awareness among hospital staff at all levels[116]. Where details of teaching methods were reported, there was an emphasis on variety and making teaching interactive to hold participants' attention. Two studies stated that the intervention was theory-based[105, 122].

Where reported, training was mainly delivered in the trainees' workplace or a similar environment. Intensity of intervention (as distinct from length of the course or programme) often not reported and not always applicable (e.g. to an online educational resource[118]). Most training interventions were one-off events, although the possibility of repeating the 'child protection week' annually was mentioned[116]. Five of the studies had some form of formal follow-up[101, 103-106] and one involved a four-month break as part of the intervention[122].

In summary, the studies varied widely both in details of the interventions and in the detail of reporting and most reported positive effects on self-reported participant outcomes. Few details were reported of the cost and resource implications of delivering training but it was not clear that longer or more complex interventions delivered better outcomes than shorter and/or simpler ones. The heterogeneity of the interventions and the associated reports limits the conclusions that can be drawn about which components were more likely to be associated with positive outcomes

Table 13: summary of components of training interventions

| Reference | By whom | What | Where | To what intensity | How often |
|---|---|---|---|---|---|
| Brewer 2012[116] | Child protection week was organised by Child Protection Forum at the hospital for all hospital employees. | A week to raise awareness of child protection using multiple sources. | Throughout hospital and on intranet | Displays and events throughout 1 week | Potentially the week could be repeated annually |
| Hackett 2013 [117] | In all cases, training was delivered by external facilitators, usually staff from local specialist projects working in the area (mainly NSPCC or Barnardo's). | The courses were designed for professionals involved in carrying out assessments and interventions with young people with harmful sexual behaviour. The aim was to develop practical skills in recognising and responding to the needs of young people in an interagency context. The courses were offered to staff who had already completed an ''Introduction to | Not reported | Each course offered 20-25 places | Each course lasted for 1 day. |

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| | | Safeguarding'' course. The courses employed interactive learning and teaching methods as well as presentations of case studies, research findings and statutory guidance. Time was allowed for discussion and exploration of personal attitudes to young people who display harmful sexual behaviour. Interactive sessions were interspersed with role plays and practical communication exercises. Informal opportunities to network over lunch and tea breaks were an important part of the programme | | | |
| Harris 2011 [118] | In 2005, the Department of Health (England) commissioned a working group to develop an educational resource on child | The content of the handbook was organized into five sections: 'Responsibility' (the responsibility of the dental team to be knowledgeable about | The handbook was sent free of charge to all NHS dental practices and salaried primary dental care services (c. 9,000) in England in May/June 2006 and the website published concurrently | Not reported | Not reported |

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| | protection for primary care dental teams. Working in association with the Committee of Postgraduate Dental Deans and Directors (COPDEND), the working group designed the 'Child Protection and the Dental Team' handbook and website to give all members of the dental team a basic awareness of child protection issues so as to encourage them to identify local contacts for advice and referral. | child protection), 'Recognising' (how to recognise abuse and neglect), 'Responding' (what to do if abuse or neglect is suspected), 'Reorganising' (making organisational changes within the practice to meet child protection responsibilities) and 'Resources' (additional information to photocopy/download). | (http://www.cpdt.org.uk/). Different distribution arrangements applied in other parts of the United Kingdom. | | |
| Hudson 2018[119] | Stop it Now Wales staff with support from host organisations | Two-hour educational programmes: Parents Protect; Internet safety; Sexual development in pre-and post-pubescent | Host organisation premises | Unclear, however most participants stated that they had discussed the programme with | Appears to be one-off intervention with evaluation immediately after |

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| | | children; Preventing child sexual exploitation; and Professionals Protect | | their children and would pass on their learning to others. | participating |
| Jackson 2017[104] | The course was developed by a central steering group of GP educators with expertise from an occupational psychologist specialising in clinical education. After piloting, the course was delivered by local GP trainers in each area, with input from local safeguarding teams. | Key elements of the course were completion of an online module (now at level 3 safeguarding); involvement of simulated patients; 'goldfish bowl' teaching on 'broaching' and 'leading to action'; and involvement of local safeguarding teams. | Online and as part of required attendance for all GP trainees | Mandatory part of GP training programmes | One-off programme followed as part of GP training |
| Carpenter 2011[103] | Courses delivered by Local Safeguarding Children Board. Details of staff involved were not reported. | Two-day training courses employing a variety of interactive teaching approaches. Participants worked together in mixed interprofessional groups. Interactive | Not reported. | Full-time over two days. | One-off course in each LSCB area. |

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| | | sessions were complemented by presentations of case studies drawn from child abuse enquiries, research findings and statutory guidance, together with videos of parents and children talking about the effects of living with mental illness | | | |
| Scourfield 2012[105] | Not reported (three trainers were involved). | Course content was broadly in line with Bandura's Social Cognitive Theory (SCT). Both training days combined a range of teaching methods, including information-giving, discussion, group activities and role play. In line with SCT, Day One focused upon personality factors, with participants encouraged to reflect critically on their knowledge and values and acknowledge the difficulties and complexities of practice | Two courses were delivered in hotels and one in local authority premises. | Full-time over two days. | One-off course without planned follow-up |

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| | | situations involving fathers. Day Two highlighted behavioural factors, with skills developed for working with reluctant clients using Motivational Interviewing. Further details of course sessions were reported in the paper. | | | |
| Keys 2005 [120] | Child Protection Adviser training primary health care teams in a Scottish NHS Trust | Training programme in child protection | Generally health centres | Over 1 year 23 primary care teams were offered the training and it was delivered to 22 teams. The training consisted of 4 sessions. | Child protection training was received once by each primary healthcare team. |
| Lewis 2017[101] | Each training session was delivered by a health care professional and a local children's social work professional. | The training addressed the following issues: linking DVA and CS in practice; holding difficult conversations about DVA and speaking directly with children; responding to DVA disclosure; child protection referral process; working with other professionals; and | Training was delivered to individual general practice teams as a 2-h safeguarding level 3 session during lunchtimes on each practice premises. | Safeguarding level 3 course | One-off course with follow-up after 3 months. |

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| | | record keeping, safety and confidentiality. Teaching was interactive, emphasising discussion and reflection on practice. Sessions included a film interspersed with short narratives from a practicing GP and a social worker. | | | |
| Smikle 2017[106] | Course delivered by a 'nationally recognised training provider'. | Five-day child protection supervision skills course. The first three days focused on theoretical frameworks, risk assessment and adult learning styles, as well as implementing the knowledge in practice. The remaining two days involved role play as supervisee and supervisor. This included peer and trainer feedback to the trainees. | Not reported | 5-day course with follow-up workshop after 9 months. | One-off training course (with follow-up workshop in this study) |
| Watkin 2009[122] | Facilitator with prior experience of working with health, education | IPL based on modified contact hypothesis theory. The programme consisted of one pre- | Not reported | The first four team meetings were held monthly and the | One-off intervention over 8 months. |

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| | and voluntary sector groups. | programme meeting between individual participants and the facilitator, and five two-hourly meetings where the facilitator met with the whole team. At the first meeting each team was encouraged to establish goals to overcome some of the difficulties that affected their ability to work together effectively. Groups of two or three participants worked toward their agreed goals and liaised with one another between meetings | | fifth after a 4-month gap to allow assessment of team performance without the facilitator. | |

Table 14: summary of components of service development initiatives

| Reference | By whom | What | Where | To what intensity | How often |
|---|---|---|---|---|---|
| Bajaj 2006 [138] | Children's Liaison and Discharge Co-ordinator | Coordinator raises awareness, training, provides advice, ensuring documentation is completed, investigate and follow-up concern raised and involvement in monthly meetings to review child protection concerns. | Child Protection Team Peterborough District Hospital | Initial post for a year, one full-time coordinator employed and workload meant a second part-time coordinator was employed. Coordinators available 8-5pm for advice, investigate concerns. Monthly meetings to reviews child protections concerns raised. | Monthly meetings to review any child protection concerns raised within the trust but available for advice and to investigate concerns on a daily basis. |
| Creighton 2016[160]; Hodes 2017[140] | Team led by consultant paediatrician with gynaecologist, specialist nurse, psychotherapist. Play specialist support. Independent interpreters and telephone interpreters are available if | Genital examination using a colposcope. Where FGM is confirmed, testing for blood-borne viruses (BBV) is recommended. After the consultation, the findings are explained to the parents, social worker and police if | Specialist paediatric outpatient clinic | Dedicated multidisciplinary service reflecting patients' complex needs | Detailed assessment with follow-up if required. |

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| | required. | present. Children and families are routinely offered a debriefing session with the psychotherapist. A small number of follow-up psychotherapy sessions can be provided in the clinic but children are referred back to local child mental health services for longer term support. | | | |
| Fifield 2011 [158] | Specialist community public health nurse (school nurse or health visitor) | 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 referral to children's services. | Location not stated but co-located with social workers and managed by social workers' manager. | Full-time position? | Regular daily basis |
| Hurley 2015[148] | Social workers involved in | International Multi Agency Assessment | Social care and related children's | As required to obtain necessary | One-off assessment with appropriate |

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| | assessing a child's needs beyond immediate protection and welfare. | Framework (IMAAF) has three domains which deal with agencies that may be relevant in understanding and assessing the child's needs; establishing the credentials of any adult(s) that may be accompanying the child; and issues in the wider environment that may be relevant to the child's situation. | services | information and provide an appropriate assessment and services. | follow-up. |
| Kaye 2009[141] | Hospital ED staff supported by mental health team | Redesigned mental health proforma with questions about children and their circumstances and prompt to complete 'cause for concern' form; 'cause for concern form specifically for children of parents with mental illness; education programme for all | Observation unit associated with ED (most patients stay overnight or a similar length of time before assessment by the psychiatric liaison team) | Intervention aimed to identify and risk stratify all dependent children of patients attending the ED for mental health problems. | One-off intervention on presentation to the ED. |

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| | | grades of medical and nursing staff. Patients were informed of any referral to social services. | | | |
| Spencer 2019[154] | Paediatric liaison nurse working 3 days per week | Paediatric liaison nursing service, promoting two-way communication between the dental hospital and other health professionals using an agreed pathway. | Service based in dental hospital | Intensity of intervention as required, including child protection referral to social services | As required while child is undergoing dental treatment |
| Whiting 2008[146] | Trained health visitors | Health specialist role, working alongside social workers to undertake joint assessments. | Local authority child welfare teams. | Intervention allows a fuller assessment than would be possible for a social worker alone and ensures health and development issues are fully covered. | As required in the context of individual cases. |

### *Service development*

The eight service development interventions suitable for component analysis (Table 14 above) comprised new roles[138, 146, 154, 158], a new service for children with actual or suspected FGM [140, 160]; and two initiatives aimed at safeguarding specific groups (migrant/trafficked children[148] and children attending the ED with fractures[141]). The new roles all involve liaison between health and social care and are staffed by nurses/health visitors. The TIDieR-Lite framework makes it possible to compare similar roles. For example, a liaison role based in an acute hospital[138] requires higher levels of staffing than a similar post based in a dental hospital[146]. All the interventions in this group are fairly high in intensity, reflecting the complex needs of the groups being served, and the frequency of intervention is flexible depending on need. For example, Bajaj et al. reported that monthly meetings are held to discuss child protection concerns but a co-ordinator is available for advice on a daily basis[138].

The findings, though based on a small number of studies, suggest that different services may have identified similar needs for service models that help different agencies to work together in safeguarding by promoting joint working and information sharing.

### *Use of data*

Component analysis was possible for three studies of initiatives involving better use of data (Table 15). All three initiatives involved data collected in clinical settings and hence required processes to be as simple as possible without sacrificing rigour. Two of the studies reported on development and piloting of the data collection instrument[164, 165], which would be important when introducing a new procedure into routine clinical practice.

Table 15: summary of components of initiatives involving use of routine data

| Reference | By whom | What | Where | To what intensity | How often |
|---|---|---|---|---|---|
| McGough 2006[164] | All staff providing clinical consultations for clients aged under 16 years. | Data recording form developed by a small group of doctors and nurses and piloted before full introduction. | Form was completed during clinical consultations at the Sandyford Initiative. | Staff were requested to complete a recording form for each attendance of a client under 16. Forms were completed for 54.6% of all attendances by female clients aged under 16 years (527/965). | The median number of visits per client was one (range, one to seven). Some 53% of clients for whom forms were returned attended only once during the study period. |
| McGovern 2015[165] | GPs, administrative staff or health visitors in participating practices. | The coding strategy was developed in May 2011. Implementation was supported by implementation packs sent to practices (November 2011); and pre-implementation training and dissemination (November-December 2011). Additional e-mail reminders to use the 'cause for concern' code were sent in January 2012. The strategy was implemented throughout 2012, with a teleconference to discuss progress in February 2012. | General practice consultations. | Minimum coding indicated child is/is not cause for concern. Additional codes covered: is the family cause for concern?; child protection/social care services involved?; and what other professionals are involved? | Concerns were recorded at all relevant consultations |
| Mitchell 2019[166] | Paediatrician | Review to assess risk of physical abuse followed by skeletal scan if necessary | Hospital emergency department | Not applicable | Once |

## Reviews

See Chapter 4 below.

# Chapter 4: Safeguarding: Findings from the International Review Literature

Internationally, lessons on safeguarding policies and procedures can be learned from the review literature, complementing the UK-focused perspectives yielded by the initiatives and strategy documents. Although countries have different health care systems and social and legislative contexts, many demonstrate an awareness of the duty of care required from health and social care organisations and all staff employed by such agencies. Identified reviews differ considerably in terms of both the aspects of safeguarding examined and the degree of systematicity that they exhibit. Broadly speaking the evidence from reviews is organised along disciplinary lines with the medical and health literature displaying a higher prevalence of conventional systematic reviews and the social care literature being largely occupied by narrative approaches.

**Aims:** The purpose of this review of reviews was to explore the evidence, issues and explanations required to understand how safeguarding is managed in health and social care organisations, nationally and internationally, and thus place individual initiatives and policies in a wider context.

## Summary of Review Characteristics

Sifting of abstracts and follow up of references identified 27 reviews. Review characteristics are detailed in Table 16.

### Table 16: Review Characteristics

| Characteristics | No. of Reviews | % of Reviews |
|---|---|---|
| **Type of Review** | | |
| Systematic Review (assessed by AMSTAR) | 9 | 33% |
| Literature Review (assessed by AMSTAR) | 2 | 7% |
| Integrative Review (assessed by AMSTAR) | 1 | 4% |
| Other Review Types | 15 | 56% |
| | | |
| **Quality of Publication (12 Reviews)** | No. | % |
| Low Risk of Bias | 8 | 66% |
| Moderate Risk of Bias | 1 | 9% |
| High Risk of Bias | 3 | 25% |
| | | |
| **Dates of Publication** | No. | % |
| 2016-2020 | 11 | 41% |
| 2011-2015 | 6 | 22% |

| | | |
|---|---|---|
| Before 2011 | 10 | 37% |
| | | |
| **Number of Included Studies** | No. | % |
| Not Stated | 10 | 37% |
| 0-5 | 1 | 4% |
| 6-10 | 2 | 7% |
| 11-15 | 4 | 15% |
| 16-20 | 1 | 4% |
| 20+ | 9 | 33% |
| | | |
| **Settings** | No. | % |
| Health and Social Care | 8 | 30% |
| Health Care (General) | 7 | 26% |
| Health Care (Specific e.g. emergency departments) | 5 | 19% |
| Social Care | 3 | 11% |
| Primary Care | 1 | 4% |
| Other/Not Applicable | 4 | 15% |
| ** Categories add up to > 100% as they are not mutually exclusive* | | |
| | | |
| **Topics covered** | No. | % |
| A&E/Emergency Department | 5 | 19% |
| Adolescent Safeguarding | 1 | 4% |
| Assessment | 1 | 4% |
| Child Abuse | 2 | 8% |
| Child Maltreatment | 3 | 11% |
| Child Protection | 1 | 4% |
| Child Safeguarding | 1 | 4% |
| Child Sexual Exploitation | 3 | 11% |
| Cyberbullying | 1 | 4% |
| Disabled Children | 1 | 4% |
| Domestic Violence | 2 | 8% |
| Education and Training | 4 | 15% |
| Information/Reporting Systems | 1 | 4% |
| Oral Health | 1 | 4% |
| Procedures/Interventions | 3 | 11% |
| Role of Specific Professions | 4 | 15% |
| Screening | 3 | 11% |
| ** Categories add up to > 100% as they are not mutually exclusive* | | |

Nine of the 27 reviews were classified as systematic reviews. Two further literature reviews and one integrative review were also considered to possess a degree of systematicity. All 12 of these studies were assessed using the AMSTAR appraisal tool. Fifteen reviews were included for their topic coverage but with certainty of review quality. Just under half of the reviews were published in the period 2016-2020 and therefore represent the most contemporary available evidence. Five additional reviews were published within the period 2011-2015 meaning that approximately two-thirds of the reviews drew upon literature published within the last ten years. Seven studies were published before 2011.

Eight of the included studies examined a combined health and social care setting. Seven studies targeted general health care with five aimed at a specific health setting (i.e. emergency departments). Three studies explored social care and one primary care. Three

studies were not specific to a particular setting and one of the included health care studies also included school settings (i.e. the role of the school nurse).
The lack of systematicity within the included reviews is indicated by the fact that nine reviews did not specify the number of included studies. Nine studies included twenty or more studies demonstrating that included reviews tend to explore broad topics rather than the focused questions addressed by systematic reviews. In fact, several of these larger reviews did not specify the exact number of included studies but manual inspection revealed numbers of studies in excess of 20.

Terminology covered by review titles tends to favour particular concepts at certain periods of time. Several of the terms such as child abuse and domestic violence were promulgated by older articles. More recent articles tended to favour the language of child sexual exploitation. Similarly, the more inclusive language of safeguarding is starting to dominate over child protection.

Several reviews defined their scope in terms of the profession being targeted as the audience (e.g. school nurse, health visitor, paramedic or general practitioner). These tend to be front-line practitioners, typically working in primary care. A related focus saw a single review target oral health rather than a specific role, emphasising the importance of occasional single contacts as a mechanism for identifying potential safeguarding issues. Potentially, practitioners who do not encounter high numbers of children requiring safeguarding could benefit from overviews of issues specific to their disease area, particularly as this extends beyond protection to the identification of neglect.

An alternative approach is to target the setting with five reviews focusing on accident and emergency department settings. Two of these reviews set in emergency departments focus on screening, attesting to the particular demands of this setting. Increasingly, the Internet has become a venue for child exploitation – demonstrated by the identified systematic review of cyberbullying. Populations targeted by reviews are largely children and adolescents in general, although one review examined the special needs of disabled children.
Education and training (four studies) was presented as the principal type of intervention, as revealed by the review literature. Several reviews included a heterogeneous collection of interventions or procedures, further revealing how the topic is more suited to broad overviews

rather than tightly-formulated systematic review questions. One review looked at reporting and information systems.

One of the valued aspects of a review of reviews is how reviews contribute collectively to an overall composite picture as they relate to each other. As can be seen from the above description of included reviews this is not the case for this review of reviews. With the exception of the reviews targeting individual professional roles and those sharing an emergency setting, few topics demonstrate a critical mass of evidence. The following analysis focuses first on these small clusters of related reviews and then moves on to consider the contribution of the remaining reviews.

### Considerations of Child Maltreatment, Child Sexual Exploitation etcetera

Bunting 2010 [167] assign the causes of non-reporting to one or more of the following broad themes: case/abuse characteristics, professional characteristics, attitudes and beliefs and organisational characteristics and education and training. They observe that emotional abuse was generally the least likely type of abuse to be reported. Gilbert 2009 [168] highlights that the emphasis of a child-safety policy on substantiation is linked with blame, punishment, and criminalisation of child maltreatment. They argue that this association creates potentially damaging stigma and, at times, a requirement to furnish evidence before protective or therapeutic interventions can be offered. This burden of proof can also limit prompt and timely provision of services. They conclude that it is important to pursue an approach that combines a focus on child safety with the broader benefits of a focus on child and family welfare.

### Specific Roles

The health visitor role is seen as one of the core roles in relation to safeguarding Akehurst 2015 [14]. Issues cluster around risk factors, signs and indicators, barriers to identification and the use of assessment tools/frameworks. Risk factors about which the health visitor should be aware should include:-

- Child-related risk factors - young age particularly under 1, low birth weight and prematurity and child disability.
- Parent-related risk factors – domestic abuse, parental substance misuse and parents with poor emotional wellbeing.

- Societal level risk factors - poverty.

These factors can be useful indicators for health visitors of the increased probability of child neglect within a family but fail to conclusively establish the presence or absence of neglect. Neglect is notoriously difficult to identify and can have negative long-term effects on a child's physical, emotional and social health. Professional supervision, the use of assessment tools and frameworks, multi-agency training, and early intervention are nominated as potential strategies to safeguard children.

In relation to school nurses Harding 2019 [15] highlights that little in-depth research examines the school nurse's role in safeguarding children and young people from maltreatment, and how this translates into daily practice. The school nurse role fulfils diverse activities to help protect children and young people from maltreatment. School nurses may face challenges in fulfilling this role, including managing heavy workloads and working with complex cases of maltreatment.

Woodman 2014[169] signals how GPs are well-placed to provide direct responses to children and families as well as participate in existing systems to safeguard children. Conversely, direct responses are not well-defined or understood. In the absence of strong evidence, the authors suggest that the safest way of GPs enacting direct responses is within the context of multiagency working. This suggests a role for multi-agency specifically for working in risk reduction, rather than the wider benefits of multidisciplinary communication, knowledge sharing and information exchange. Overcoming such reluctance by broadening the GP's role to include direct responses to maltreatment-related concerns would, the authors argue, play to the existing strengths of general practice and maximise GPs' contribution to a public health approach to child maltreatment. The authors further highlight a need for randomised trials to evaluate what works and for whom in the way that GPs in the UK respond to maltreatment related concerns.



## Education and Training

Education and training seem to offer an attractive intervention within safeguarding, an area that requires a high level of procedural knowledge, continual refreshment of knowledge of the regulatory and legislative environment and which carries a high degree of potential risk.

However, one review by Ogilvie-Whyte 2006 [170] cautions that education and training interventions have been poorly evaluated. Notwithstanding high investment in training funds, evaluations have neither established the overall level of effectiveness nor the respective benefits of different alternatives for delivering such training. The authors found sufficient studies to suggest that the evidence base for training and education in the context of safeguarding will ultimately prove an effective way of improving outcomes for clients but concludes that at the moment methodological and practical problems stand in the way of definitively establishing this evidence base.

Carter 2006 [4], in a review of procedural and training interventions, reported that training interventions were in the majority, including 15 training interventions and only 7 procedural interventions from the 22 studies identified. Most of these training interventions were training programmes for a multi-professional audience, often in a community/primary care setting. Again, the authors report limitations in the methodological quality of the evaluations of the training programmes (an absence of control groups, objective outcomes and long-term outcomes., meaning that it was not possible to make firm conclusions about their effectiveness. However, the authors conclude that several training interventions were potentially effective, particularly highlighting those that use adult learning theory and information technology.

Several other reviews suggest that training Schrader-McMillan 2017 [171], particularly multi-agency training Akehurst 2015 [14] Bunting 2010 [167], offers a potential route towards safeguarding strategy. However, taken as a whole they lack evidence to establish this suggestion.

Bunting 2010 [167] identify multiple broad factors that result in underreporting of child abuse; one of these relates to education and training. They identify a potentially useful overall curriculum for appropriate training programmes (See Box). Sanders 2005[172] highlights, in the specific context of Accident and Emergency staff, a need for improved training in social as well as clinical risk factors, in order to address the under-reporting of non-accidental injuries in young children. Again, this attests to the value of multidisciplinary and multi-agency training initiatives. Fraley 2019 [173] suggests that curriculum design should involve focus groups of nurses, content experts, and survivors if it is to enhance programmes specifically tailored to various health settings and thereby strengthen intervention results. Such a tailored approach within a collaborative framework holds the potential to strengthen a multidisciplinary population health response.

*Box 1 - Components of a Training Programme Bunting 2010 [167]*

- Identification of the signs of child abuse and neglect
- Direction on what, when and how to report concerns
- Consideration of obstacles and concerns faced by different professionals in reporting child protection concerns.

*This training could be included in undergraduate and postgraduate education as well as in continuing professional development education and training.*

In the specific context of school nurses Harding 2019 [15] identify a need for training to address "the complex and evolving nature of child maltreatment" at both service planning and front-line levels. They suggest that training for school nurses could not just cover policy and processes, but also communication skills and managing relationships with both the child and family. They also hint at a tension that may be even more pronounced for other health professionals, whereby safeguarding is seen as everybody's business yet day-to-day demands make it challenging to access training and development to what are, after all, a relatively small and yet critically important part of their identified learning needs. Bradbury-Jones 2019 [174] similarly identifies how child safeguarding issues may arise in connection with oral health, pointing out that dental practitioners are well-placed to detect some of the more obvious physical signs of physical neglect in children.

Professionals who have continuous contact with children, such as people working in schools and community health services, can play a leading role in recognising, responding to, and supporting maltreated children Gilbert 2009 [168]. Other professions, such as paramedics, do not require such continuity in their role in meeting the needs of vulnerable children. Nevertheless, they fulfil an equally important role as a potential point of first contact. Johnson 2018 [7] sought studies describing formal training in frontline identification and mandatory reporting of abuse and neglect of children (0–12 years) targeting paramedics, ambulance personnel and emergency medical technicians. Notwithstanding some of the methodological limitations highlighted above they identified four publications (three cross-sectional studies and one one-group pre-test post-test study involving 2499 subjects) that demonstrated a consistent pattern, namely that higher levels of training correlated with greater knowledge and/or confidence regarding both the identification process and the correct procedures for reporting child abuse. One might hypothesise that outcomes for training

programmes are easier to capture and measure for identification and mandatory reporting than for other "softer" training components such as improvement in communication skills and relationships management.

Ellison and colleagues (Health Working Group 2014[175], writing in 2014 in a report targeted at health professionals working in and outside the NHS, comment on how professional awareness of child sexual exploitation had improved in recent years. Nevertheless, they observed that better training was needed to assist practitioners in identifying and helping children who have been abused.

### Other procedures and interventions

Carter 2006 [4] identified seven studies reporting procedural interventions, including the introduction of forms, flowcharts or reminder checklists to guide clinicians in identifying and managing potential child abuse cases within secondary care. The review found that the use of checklists and structured forms can result in improved recording of key information and could help alert staff to the possibility of abuse. Such documentation could offer a focus for the content of education and training programmes. As with the training interventions that also featured in this review the authors identified a general absence of rigorous evaluations.

### Information and Reporting Systems

Léveillé 2010[176] identified that successful implementation efforts were associated with several organisational factors, identified within an overarching framework, the Framework for the Assessment for Children in Need and their Families (FACNF), including the use of information technology. Sanders 2005[172] identified how bureaucratic and interprofessional barriers to identifying abuse included difficulties in obtaining information from social services. However, this was in the specific context of accident and emergency departments and a general focus on the need for improved interagency working throughout the literature would suggest that problems lie in relation to two-way flow of information, dependent on the perspective of the study or commentator. Bunting 2010 [167] makes an explicit link between the role of organisational factors in information sharing and reporting and the importance of training, pointing to positive indications that training can increase professional awareness of reporting processes and requirements and help to increase knowledge of child abuse and its

symptoms. This shapes the nature of training, requiring that it extend beyond simple awareness raising; they specify a need for on-going multidisciplinary training tailored to address the diverse factors which impact on reporting attitudes and behaviours. The complex interaction between training, information systems, communication sharing and information sharing emphasises the need for a multi-pronged "whole systems approach", rather than pursuit of one or two isolated yet favoured interventions.

### Screening Interventions

Screening is a key component of an organisational safeguarding response, particularly for front-line responders. Woodman 2010[11] highlights the challenge that this presents, finding that none of the markers in physically abused or neglected children and non-abused injured children attending the emergency department or hospital were sufficiently accurate to screen children for possible abuse or neglect. In an earlier technical study Woodman 2008[10] had reported clear evidence that physically abused children attending the Emergency Department are missed, concluding that the performance of clinical screening assessments was poorly quantified. They had already found no evidence that any test was highly predictive of physical abuse. Evidence that a community liaison nurse improved the performance of the screening assessment was rated as only "weak". The addition of screening protocols to clinical screening offered marginal benefits. The reviewers conclude that the most effective protocol was to refer all injured infants and children who were known to social services. Their overall conclusion is that Improving clinical screening is likely to be more useful than protocols in improving the detection of physically abused children in emergency department settings. However, this conclusion reflects a single disciplinary view of the safeguarding system.

Furthermore, Gilbert 2009 [168] identifies an associated need for screening and assessment questionnaires that directly question children and parents about maltreatment and thereby might improve recognition. However, they caution that research is needed to quantify how much the benefits of recognition and subsequent interventions outweigh any harms from the process for children overall. Screening and improved recognition raise an associated need for appropriate follow-up. The authors express uncertainty over whether child protection services have the capacity to respond to increased recognition of child maltreatment. James 2017 [177] points to the usefulness of the HEEADSSS psychosocial screening tool when assessing

young people (HEEADSSS - H Home E Education/Employment E Eating A Activities D Drugs/alcohol S Sexuality S Suicide/Depression S Safety) but again the ramifications of this must be examined within an overall systems approach.

## Other Review Findings

Aboujaoude 2015 [13] examines the recent phenomenon of cyberbullying. While cyberbullying has many of its own distinguishing characteristics, for example anonymity and the substitution for psychological power for physical strength, behaviours have been shown to be closely linked to more traditional forms of bullying. This suggests that mechanisms to counter such bullying may lie within an overall system response rather than specifically targeting Internet and social media behaviour.

## Discussion and Conclusions

Reviews identify very few different types of intervention for contributing to safeguarding policies and procedures. Essentially, these involve training and education, improved information systems and information working, documentation and interagency working. Within these categories considerable variation exists with regard to target staff groups, intervention components and clinical settings. These factors combine to make synthesis challenging. It seems likely that an optimal response would seek to combine multiple strategies operating under a complex systems lens. Generally, therefore, the review literature fails to demonstrate a coherent and coordinated agenda for research and subsequent action. This justifies a subsequent emphasis on the richness of context and intervention detail provided by the individual strategies, policies and interventions.

## Future research directions

The prevalence of education and training interventions as a common response to the challenges of safeguarding reveals a critical dependency upon the quality and results of evaluations. Within the area of safeguarding, education and training share many of the limitations reported for other aspects of medical, nursing and health care continuing education and development, namely a shortage of control groups, objective measures and long-term follow up. These offer a ready target for improved research and evaluation. Until

such studies are available, trust in the effectiveness of training and education remains very much an act of faith [170].

# Chapter 5: Discussion and conclusions

## Main findings

This review sought to establish what interventions are effective (including cost-effective), feasible and acceptable for promoting awareness and supporting prevention of harm in safeguarding children and young people in health and social care settings. We defined awareness broadly to include the ability of the wider system, not just individuals, to process relevant information and respond appropriately. This inclusive approach led us to include some 180 papers in the review, all (with the exception of literature reviews) from UK settings. The studies covered the whole range of health and social care, including general practice, hospital and community care and the interface with social care (see Tables 7 to 11). A number of studies highlighted the importance of dentists and other dental health professionals [107, 118, 154].

While many studies were relatively well conducted, the evidence base comprised mainly cross-sectional or before/after studies with no control group and limited follow-up. Evaluation often took the form of surveys/questionnaires or qualitative research with few studies reporting service-relevant outcomes.

In synthesising the evidence on interventions, we distinguished between studies describing or evaluating strategies (multiple components and updateable) and those focusing on initiatives (generally one-off projects with fewer components to the intervention). The research studies of strategies frequently identified barriers to their implementation at different levels of the health and/or social care system[18], although some promising frameworks and service models were identified[1, 25]. Strategies were often issued as policy or guidance documents by UK government departments, devolved administrations within the UK, charities, NHS bodies or some mixture of these. This substantial body of documents appears to have made little impact on the academic sector to judge by the negative results of a citation search based on those included in this review.

The largest group of included studies dealt with initiatives and most of these fell into three groups. Training is the most obvious way of raising awareness of safeguarding issues and the largest group of studies dealt with training initiatives. The initiatives identified varied considerably in terms of duration and intensity and involved participants from health, social care or both. Some studies involved participants from other related fields such as education and the justice system. Most studies reported that training improved participants' reported knowledge, confidence or attitudes towards safeguarding but the evidence overall was of low quality with no control groups and little or no follow-up. Studies published as recently as 2018 continue to advocate the need for further training, for example on recognising abusive head trauma[113].

Another group of initiatives involved development of services in health, social care or both. Some promising initiatives were identified, particularly those involving new roles or processes to promote effective working between health and social care[146, 153, 154]. At the same time, interagency working was frequently identified as a challenge to the successful implementation of initiatives[147, 150].

A small group of four studies looked at initiatives involving use of routine data to improve awareness of potential safeguarding risks, for example when children regularly miss scheduled health appointments[163]. Improved recording or coding of data[165] and reduction of variation between institutions[166] both appear to be promising approaches.

The group of cultural/organisational studies cast further light on the themes identified in the studies of initiatives, including the roles of different professional groups, interagency working and use of data. Cultural differences between organisations can make it easier or more difficult to work together effectively and insights in this field can help to support successful implementation of initiatives. Such differences may cover different views of how best to go about safeguarding but also practical problems such as differences in IT systems making it difficult to exchange information[20, 158].

The 27 literature reviews included in this review comprised both systematic and non-systematic reviews. The topics covered were similar but the inclusion of literature reviews allowed us to consider international evidence alongside evidence from the UK.

The overall evidence base from primary studies and reviews comprised mainly cross-sectional or before/after studies with no control group. Evaluation often took the form of surveys/questionnaires or qualitative research using interviews or focus groups. Hence, this extensive group of studies provides little hard evidence of effectiveness, a conclusion also reached by Luckock et al. in their scoping review of service models for neglect [1]. There was also almost no evidence on costs or resource use let alone any attempt at economic evaluation.

Other characteristics of the overall evidence base were the emphasis on promoting interagency working and some of the pitfalls involved; identification of the number of professional groups involved in safeguarding (an issue also highlighted by our PPI group); and a lack of involvement of children and young people themselves. Of the included studies, 76 did not include children or young people at all (for example studies of health professionals or use of data) and the remainder mainly involved them as study participants. As an example of a group whose importance could easily be overlooked, the mapping review highlighted the important role of dentists and dental services in a range of different aspects of safeguarding [22, 23, 107, 154].

Finally, many of the studies included in this review were conducted between 2008 and 2018 against a background of reduced public expenditure in the UK, particularly for social care services provided by local authorities. Pressure on resources was sometimes identified as a limitation on successful implementation of strategies[18] or initiatives such as training[127].

## Strengths and limitations

The inclusive approach to awareness adopted in this review is a strength in that it should encourage decision-makers to focus on all aspects of the health and social care system, not just on providing training for individuals or groups. We included studies published between 2004 (date of important legislation affecting safeguarding) and 2019. The included studies as a group show how the evidence base has evolved over time and allow identification of perennial themes. A limitation of this approach is that older papers are likely to be less relevant to current practice. This is reflected superficially in terms of language used (for example, ‘child protection’ in earlier papers and ‘safeguarding’ in more recent ones) but more fundamentally in intrinsic philosophies and cultures revealed in papers from different eras.

The review was conducted rapidly by a small team. Methodological strengths include a thorough search, including citation searching and use of the TIDieR-Lite framework to characterise interventions. Study quality was assessed using standard tools when study design and reporting made this possible. We used a number of methods to abbreviate the review process. Verification of items for inclusion/exclusion was limited to a 10% sample and undertaken retrospectively. Inclusion of items was informally checked by discussion of any uncertainties during later stages of the review. A further methodological short-cut was the use of one checklist (the JBI checklist for quasi-experimental studies) to cover a range of different study designs. This avoided the use of a number of different checklists for a small number of studies each and the checklist used was considered to cover aspects of quality (for example, control group, follow-up) relevant to the review.

Limitations of the evidence base included lack of long-term follow-up, control groups and data on service-relevant outcomes. This may reflect in part a difference in research culture between healthcare and social care research. There were also limitations in reporting which limited our ability to draw conclusions from the component analysis, although the main limiting factor was the diverse range of initiatives identified and included in the review, even within a broad group such as training initiatives. As noted by a reviewer of this report, there was a lack of studies on safeguarding in the transition from adolescence to adulthood and only one review included in Chapter 4 focused on adolescent safeguarding.

## Relationship to previous reviews

We believe this to be the first evidence synthesis to address awareness of safeguarding issues across the whole range of health and social care. The review of international evidence from systematic and non-systematic reviews presented in Chapter 4 identified 27 relevant reviews, of which just nine were classified as full systematic reviews. Many of the included reviews focused on safeguarding awareness in specific professional roles (e.g. school nurse, health visitor, paramedic or general practitioner) or settings (five reviews were specific to emergency departments). With the exception of these groups, few topics had a significant volume of review-level evidence. The current review has made an important contribution by drawing together and summarising this disparate body of synthesised evidence. In considering the evidence, it should be remembered that we did not have the time or resources to evaluate overlap of primary studies between reviews. This means that a number of

published reviews may be a less impressive body of evidence than appears at first glance. Importantly, however, key findings about the need for more rigorous evaluation of training initiatives emerged from both the international review of reviews and the mapping review of UK primary studies.

## Implications for service delivery

- All services need to be aware of safeguarding issues, not just those serving at-risk groups.
- The review (particularly the review of reviews) identified tensions between safeguarding being everyone's business and identified requirements for training which need to be proportionate to need and other competing roles and responsibilities[15, 174] .
- Roles vary between those who may be a first point of contact for identifying safeguarding concerns (e.g. A&E staff, dentists), those for whom safeguarding forms a major background to their daily work (e.g. school nurses, health visitors) and those who provide specialist support within a safeguarding pathway.
- Evidence-based guidance is available from diverse sources, statutory and voluntary, and regularly updated (see Chapter 3, section on 'Policies/guidance).
- Some promising initiatives have been identified, e.g.: liaison nurses[138, 154], assessment clinics[160], secondment[146], joint protocols[153], and a 'hub and spoke' model[145].
- We identified only a few studies of use of data but this approach appears promising. However, service providers need to consider the acceptability of data recording and ensure protection of confidentiality for service users.
- Training is essential for improving service quality but service providers need to consider what level of depth and intensity is appropriate for particular staff groups and be aware that even simple initiatives can have an impact on safeguarding awareness[116].
- Service providers should seek to be aware of organisational culture (their own and of the organisations/ agencies they work with) and how their services are perceived by young people, families and wider community.
- Safeguarding services need to deal with a prevalent tension between "case finding" within a blame culture and wider support to the child and whole family.

## Implications for research

- There is a need for continued mapping and evaluation of service initiatives building on the work of Luckock et al.[1] Longer term studies with outcomes relevant to service users are needed.
- Effective collaboration between different agencies is vital for effective safeguarding. Examples of initiatives that could benefit from further research include secondment of staff between health and social care; professional roles with a mandate to support joint working and information sharing; and use of joint protocols by health and social care professionals.
- Research is also needed to optimise the use of routinely collected data to support the identification of children and young people who may be at risk of abuse. This could involve development of innovative tools but improvements in the quality and consistency of data coding would also be a valuable research topic.
- Involvement of children/young people and family/carers in research and intervention design is essential and may also inform design of training curricula.
- Evaluations should include investigation of costs/resource use and barriers to wider implementation of promising interventions.
- Common interventions e.g. education and training, information sharing, documentation are typically not rigorously evaluated and further research on these should be considered.
- Study design should be as rigorous as possible: if a control group is not feasible, researchers could consider using a time series design or benchmark against other similar areas.
- 
- Use insights from adult learning theory/cultural studies/theory to inform research and intervention development.

## Conclusions

This systematic mapping review has identified a substantial body of research relevant to awareness (broadly defined) and prevention in safeguarding of children and young people in

health and social care settings in the UK. We have also incorporated international evidence from relevant scoping reviews. A limited number of types of interventions have been reported and most evaluations of these lack rigour in terms of the norms of applied health research. There was limited evidence in relation to children/young people and families' experience of different interventions or services. A need to extend inter-agency working is indicated from several sets of literature, particularly where this extends to joint training. Overall, the topic of child safeguarding seems to be lacking a whole system approach which would facilitate a more joined-up approach. This is particularly necessary given recurring needs expressed for information sharing and communication skills.

Our aim was to establish what interventions are effective (including cost-effective), feasible and acceptable. On effectiveness, UK and international evidence is plentiful but not rigorously evaluated. Interventions/programmes/projects are heterogeneous, making evaluation and comparison challenging. Promising initiatives supported by relatively strong evidence include liaison nurses, assessment clinics, secondment, joint protocols, and a 'hub and spoke' model. Cost-effectiveness evidence is lacking. In terms of feasibility, initiatives from a UK context offer promise but require more rigorous evaluations. The service user/client voice is noticeably lacking, limiting the conclusions that can be drawn on acceptability. There is also an absence of qualitative data on attitudes of health providers to different safeguarding strategies, procedures or interventions.



## Disclaimer

This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

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All authors commented on drafts of the protocol and report

## Data sharing

Any additional data not included in this report and its appendices are available on request. All queries should be submitted to the corresponding author.

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# Appendices

## Appendix 1: Medline search strategy

Database: Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily <1946 to October 15, 2019>

Search Strategy:

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1 Child Abuse/ or Child Abuse, Sexual/ or Physical Abuse/ (29765)

2 ((child$ or emotional$ or physical$ or sexual$) adj3 abus$).ab,ti. (28449)

3 (child$ adj3 neglect$).ab,ti. (3981)

4 Human Trafficking/ (359)

5 (human$ adj3 traffic$).ab,ti. (991)

6 (sexual$ adj3 exploit$).ab,ti. (594)

7 (child$ adj3 exploit$).ab,ti. (331)

8 (forc$ adj3 (marriage$ or marry$)).ab,ti. (148)

9 Circumcision, Female/ (1292)

10 (female adj3 circumcision).ab,ti. (452)

11 (female adj3 genital$ adj3 mutilat$).ab,ti. (1086)

12 fgm.ab,ti. (1009)

13 "hate crime$".ab,ti. (149)

14 "hate crime".kw. (19)

15 "online harassment".ab,ti. (33)

16 "Online harassment".kw. (9)

17 Cyberbullying/ (85)

18 "Cyberbullying".kw. (241)

19 cyberbullying.ab,ti. (586)

20 or/1-19 (47437)

21 safeguard$.ab,ti. (9983)

22 (safeguarding or safeguarding children or safeguarding patients or safeguarding tracking or safeguarding training).kw. (47)

23 safeguards.kw. (17)

24 child safeguarding.kw. (8)

25 Child Protective Services/ (387)

26 (child$ adj3 protect$).ab,ti. (8557)

27 or/21-26 (18583)

28 20 or 27 (63259)

29 early help$.ab,ti. (100)

30 (recognition or recognises or recognise or recognizes or recognize).ab,ti. (403776)

31 (assessment or assessments or assess or assesses).ab,ti. (1781303)

32 (prevent or prevents or prevention).ab,ti. (950947)

33 (awareness or training).ab,ti. (506627)

34 or/29-33 (3363411)

35 exp Health Personnel/ (493142)

36 (health adj3 professional$).ab,ti. (76479)

37 social care professional$.ab,ti. (436)

38 Social Workers/ (492)

39 social worker$.ab,ti. (9393)

40 (general practitioner$ or gp).ab,ti. (79597)

41 health visitor$.ab,ti. (2641)

42 (pediatrician$ or paediatrician$).ab,ti. (21831)

43 "child and adolescent mental health service$".ab,ti. (550)

44 camhs.ab,ti. (337)

45 Emergency Medical Services/ or Emergency Service, Hospital/ (102539)

46 Emergency Medicine/ (12996)

47 (emergency adj2 service$).ab,ti. (15765)

48 "emergency care".ab,ti. (8337)

49 "urgent care".ab,ti. (1889)

50 "emergency department$".ab,ti. (84659)

51 casualty.ab,ti. (5368)

52 "accident and emergency".ab,ti. (4585)

53 or/35-52 (798699)

54 34 or 53 (3977069)

55 28 and 54 (21449)

56 exp United Kingdom/ (357021)

57 (national health service$ or nhs$).ab,in,ti. (179574)

58 (english not ((published or publication$ or translat$ or written or language$ or speak$ or literature or citation$) adj5 english)).ti,ab. (92680)

59 (gb or "g.b." or britain$ or (british$ not "british columbia") or uk or "u.k." or united kingdom$ or (england$ not "new england") or northern ireland$ or northern irish$ or scotland$ or scottish$ or ((wales or "south wales") not "new south wales") or welsh$).ab,in,jw,ti. (1971592)

60 (bath or "bath's" or ((birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or

(worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in. (1325316)

61 (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in. (51753)

62 (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in. (197541)

63 (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in. (24363)

64 or/56-63 (2539980)

65 (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp oceania/) not (exp great britain/ or europe/) (10000)

66 64 not 65 (2535841)

67 55 and 66 (3429)

68 limit 67 to (english language and yr="2004 -Current") (2272)

69 MEDLINE.tw. (108519)

70 systematic review.tw. (138266)

71 meta analysis.pt. (105924)

72 or/69-71 (253748)

73 55 and 72 (543)

74 limit 73 to (english language and yr="2004 -Current") (474)

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Search step 1-19 are terms for child abuse

Search step 20 combines child abuse terms with OR

Search step 21-26 are terms for safeguarding and child protection

Search step 27 combines the terms for safeguarding and child protection with OR

Search step 28 combines the child abuse and safeguarding terms with OR

Search step 29-33 are terms for early help and recognition

Search step 34 combines the terms for early help and recognition with OR

Search step 35-52 are terms for health and social care professionals and accident and emergency departments which due to the nature of their work regularly encounter safeguarding issues.

Search step 53 combines the terms for professionals with OR

Search step 54 combines the early help and professional terms with OR

Search step 55 combine search step 28 and search step 54 with AND.

Search steps 56-66 are the UK search filter developed by Ayiku and Colleagues. Reference - Ayiku L, Levay P, Hudson T, Craven J, Barrett E, Finnegan A, Adams R. The medline UK filter: development and validation of a geographic search filter to retrieve research about the UK from OVID medline. *Health Info Libr J* 2017;**34**:200–16.

Search step 67 combines the UK search filter with the search

Search step 68 limits the results of the search to English Language papers published from 2004.

Search step 69-72 are the terms of a search filter for reviews developed by McMasters. The filter was designed to maximise specificity.
https://hiru.mcmaster.ca/hiru/HIRU_Hedges_MEDLINE_Strategies.aspx#Reviews

Search step 73 combines the reviews search filter with the search

Search step 74 limits the results of the search to English Language papers published from 2004.

## Appendix 2: Quality assessment of reviews using AMSTAR

Table 17: AMSTAR quality assessment of reviews

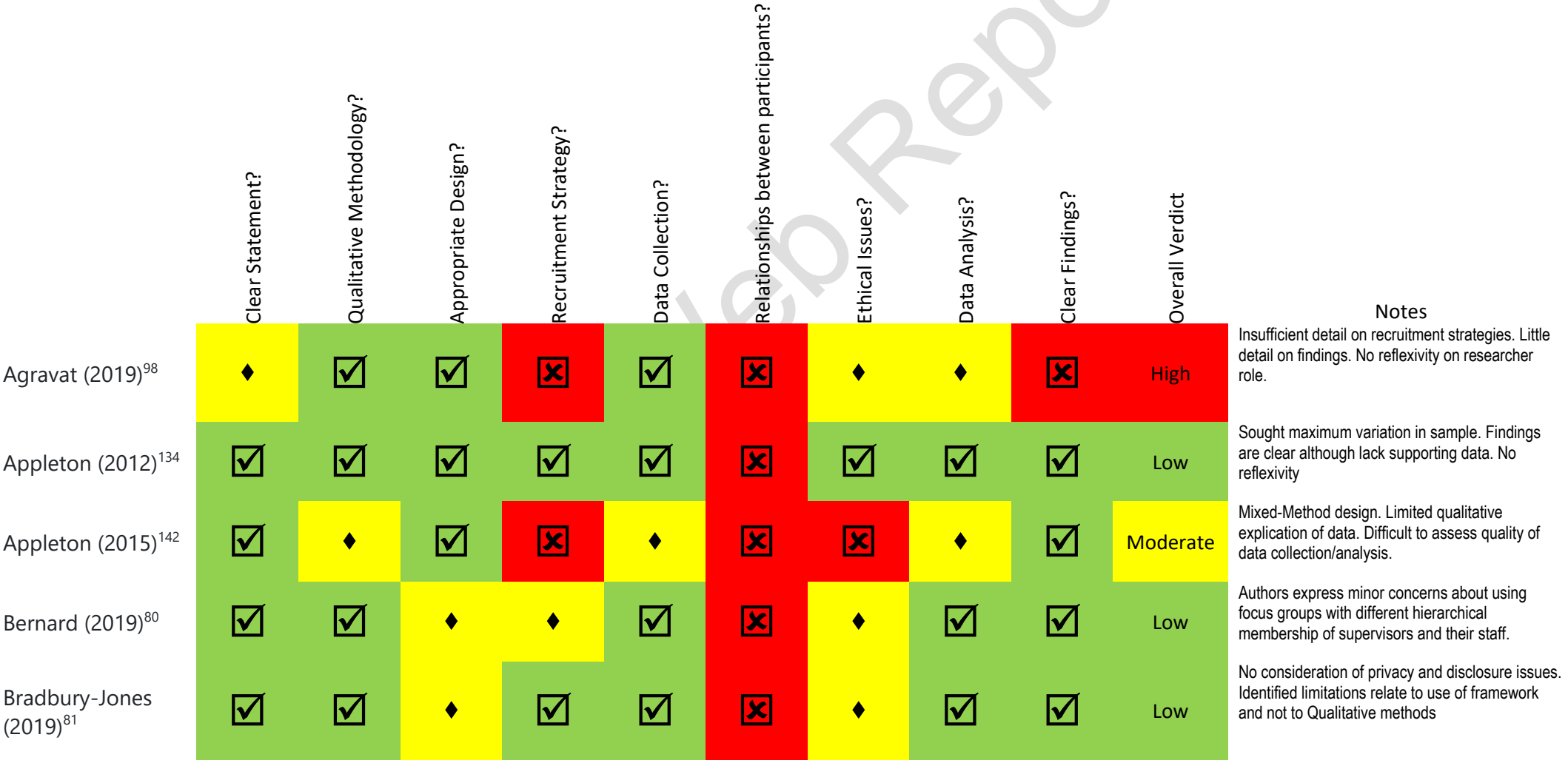
| Reference | 1. Was an 'a priori' design provided? | 2. Was there duplicate study selection and data extraction? | 3. Was a comprehensive literature search performed? | 4. Was the status of publication (i.e. grey literature) used as an inclusion criterion? | 5. Was a list of studies (included and excluded) provided? | 6. Were the characteristics of the included studies provided? | 7. Was the scientific quality of the included studies assessed and documented? | 8. Was the scientific quality of the included studies used appropriately in formulating conclusions? | 9. Were the methods used to combine the findings of studies appropriate? | 10. Was the likelihood of publication bias assessed? | 11. Was the conflict of interest stated? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aboujaoude (2015)[13] | Not applicable | No | Yes | Yes | No | No | Not applicable | Not applicable | Yes | Not applicable | Yes |
| Akehurst (2015) [14] | Not applicable | Not applicable | Yes | Yes | Not applicable | Not applicable | Not applicable | Not applicable | Yes | Not applicable | No |
| Carter | No | Yes | Yes | No | Yes | Yes | Yes | Yes | Not | Not | Yes |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| (2006) [4] | | | | | | | | | applicable | applicable | |
| Felner (2017) [5] | No | No | Yes | Yes | No | Yes | Yes | Yes | Not applicable | Not applicable | No |
| Harding (2019) [15] | Not applicable | Not applicable | Yes | No | Not applicable | Yes | Yes | Not applicable | Not applicable | Not applicable | No |
| Howarth (2016) [6] | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Can't answer | Yes |
| Johnson (2018) [7] | Yes | Yes | Yes | No | No | Yes | Yes | Yes | Yes | Not applicable | Yes |
| Lowers (2010) [3] | No | Yes | Yes | No Inclusion criteria was peer-reviewed study No searches for grey literature | Yes | Yes | Yes | Yes | Yes | Not applicable | Yes |
| Newton | No | Yes | Yes | No | No | Yes | Yes | Yes | Yes | Not | Yes |

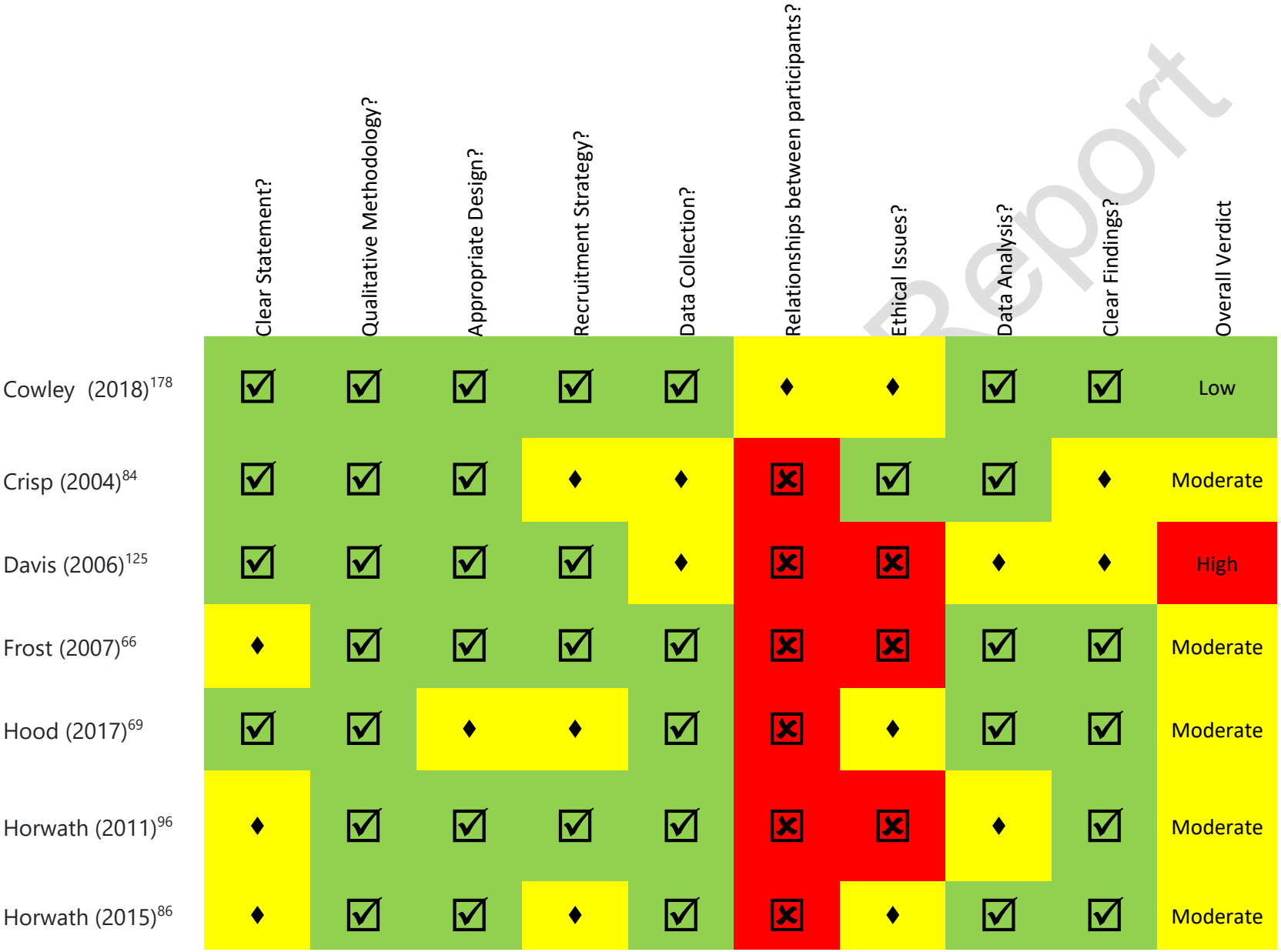
| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| (2010) [8] | | | | | | | | | | applicable | |
| Viswanathan (2018) [9] | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Can't answer | Yes |
| Woodman (2008) [10] and Woodman 2010 [11] | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Not applicable | Yes |

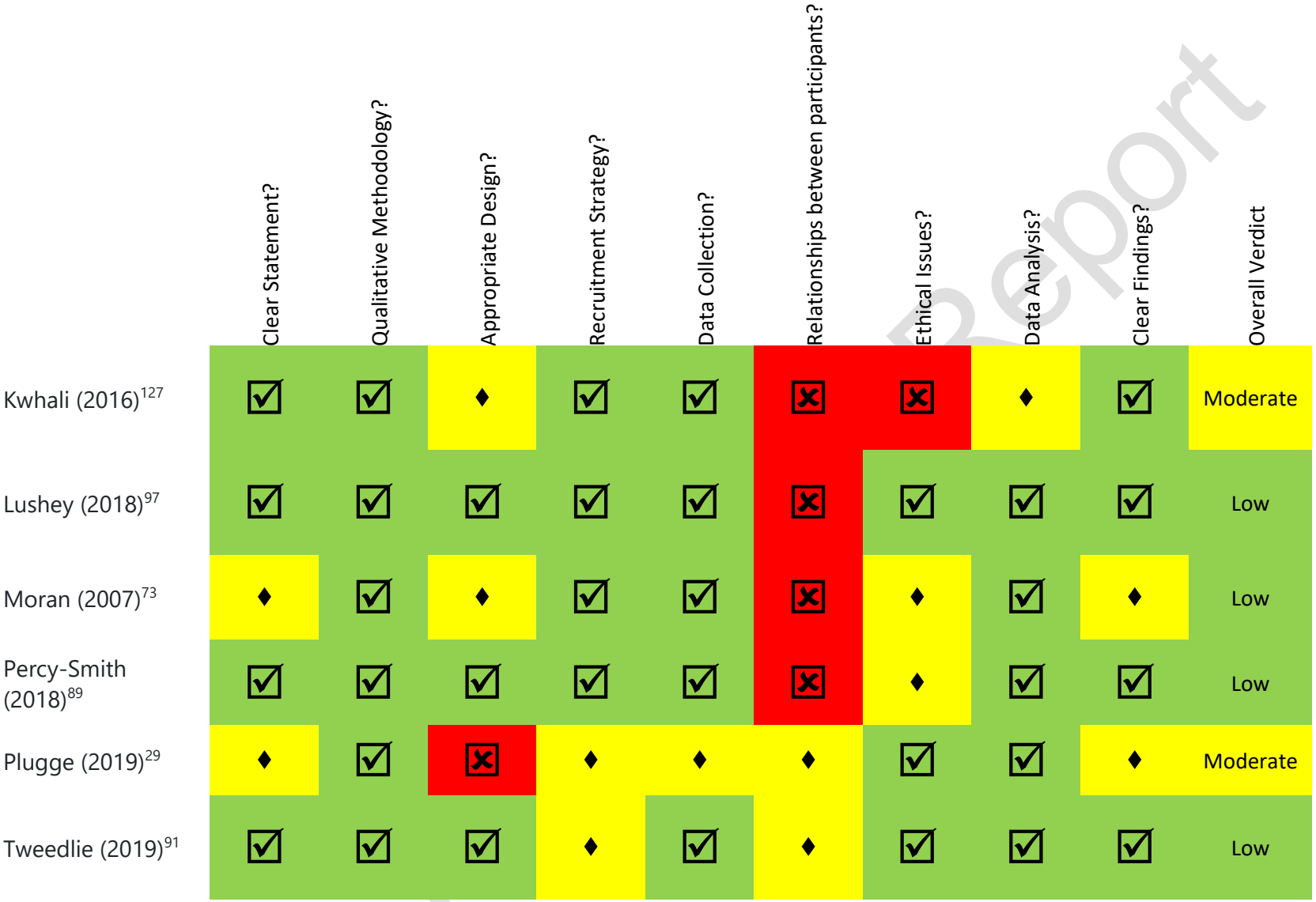
## Appendix 3: Quality assessment of qualitative studies

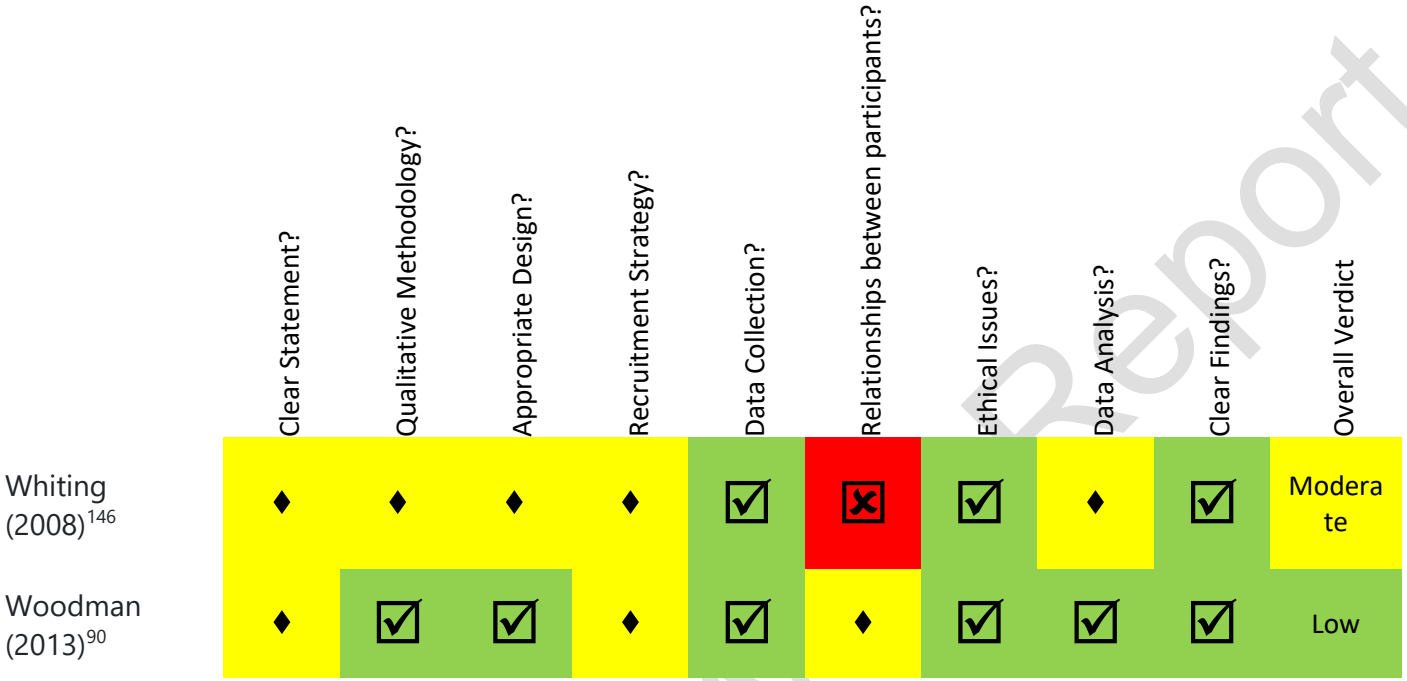
Table 18: CASP quality assessment of qualitative studies



| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Clark (2018)[110] | ☑ | ☑ | ☑ | ☑ | ♦ | ☒ | ♦ | ☑ | ♦ | Moderate | Limited synthesis across participants - presented as a case series which restricts identification of common themes. |


Clear Statement?
Qualitative Methodology?
Appropriate Design?
Recruitment Strategy?
Data Collection?
Relationships between participants?
Ethical Issues?
Data Analysis?
Clear Findings?
Overall Verdict
Notes
Cowley (2018)[178]
Low
Establishes no prior relationship between participants and student interviewer but no further details.
Crisp (2004)[84]
Moderate
Some of the respondents were not directly involved in the issue of child protection and were providing vicarious evidence.
Davis (2006)[125]
High
No detail of ethical approval or reflexivity. Little exposition of findings beyond verbatim extracts.
Frost (2007)[66]
Moderate
Framework informed evaluation but little detail on ethical approval and reflexivity issues.
Hood (2017)[69]
Moderate
Use of vignette rather than real instance. Sample was purposive but six from each profession.
Horwath (2011)[96]
Moderate
Not primary aim of study to explore this -used data from wider study. Analysis around simple codes with little exploration of interrelationships between themes.
Horwath (2015)[86]
Moderate
Not clear if question being addressed was part of original intent of data collection.


Clear Statement?
Qualitative Methodology?
Appropriate Design?
Recruitment Strategy?
Data Collection?
Relationships between participants?
Ethical Issues?
Data Analysis?
Clear Findings?
Overall Verdict
Notes
Kwhali (2016)[127]
Moderate
No identified limitations. Limited presentation of verbatim comments.
Lushey (2018)[97]
Low
Well conducted study with rich reporting of data. No reflexivity.
Moran (2007)[73]
Low
Mixed Methods study - quantitative published separately. No identification of limitations.
Percy-Smith (2018)[89]
Low
Overall good quality study. No explicit ethical approval but conducted in a way sensitive to young people.
Plugge (2019)[29]
Moderate
Unclear whthere focus groups offered sufficient protection for young participants.
Tweedlie (2019)[91]
Low
Convenience sample of nursing students but otherwise study conducted rigorously.




Notes

Conducted as a service evaluation - therefore unclear the extent to which this contributes research findings.

Clearly presented. Unclear exactly what the aim was and why recruitment criteria were specified as they were.

## Appendix 4: Quality assessment of other study designs

Table 19: Quality assessment of other study designs

| Reference | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 |
|---|---|---|---|---|---|---|---|---|---|
| Brewer 2012 [116] | Yes | Yes | Not applicable | No | No | Not applicable | Yes | Unclear | Yes |
| Gonzalez-Izquierdo 2010[93] | Not applicable | Yes | Unclear<br>Long time series so care could have changed | No | Not applicable | Not applicable | No<br>Coding changed over time | Yes | Yes |
| Gonzalez-Izquierdo 2014 [16] | Unclear | Unclear | Unclear | No | Yes | Not applicable | Yes | Yes | Yes |
| Hackett 2013 [117] | Yes | Yes | Not applicable | No | Yes<br>Measured immediately after intervention | Not applicable | Yes | Yes | Yes |
| Hudson 2018[119] | Yes | Yes | Not applicable | No | No | Not applicable | Yes | Unclear | Unclear |
| Carpenter 2011[103] | Yes | Yes | Not applicable | No | No | No<br>Follow-up achieved low response rate | Yes | Unclear | Yes |
| Scourfield 2012[105] | Yes | Yes | Not applicable | No | No | Unclear | Yes | Unclear | Yes |
| Keys 2005 [120] | Yes | Unclear | Not applicable | No | No | Not applicable | Unclear | Unclear | No |
| Devine 2015 [159] | No | Unclear | Unclear | No | Unclear | Not applicable | No | Unclear | Unclear |
| Lewis 2017[101] | Yes | Yes | Not applicable | No | No<br>Follow-up at 3 months only | Yes<br>Differences between completers and non- | Yes | Yes | Yes |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | completers were analysed | | | |
| Melling 2012 [95] | No | Unclear | Unclear | No | Unclear<br>Mixed data from Liverpool and other cities | Not applicable | Yes | Yes | Yes |
| Mitchell 2019[166] | Yes | Unclear | Unclear | No | No | Yes | Yes | Yes | Yes |
| Woodman 2012[94] | No | Unclear | Unclear | No | Yes | Not applicable | Yes | Yes | Yes |

Key to questions (https://joannabriggs.org/ebp/critical_appraisal_tools; accessed 29th January 2020)

1. Is it clear in the study what is the 'cause' and what is the 'effect'? 2. Were the participants included in any comparisons similar? 3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest? 4. Was there a control group? 5. Were there multiple measurements of the outcome both pre and post the intervention/exposure? 6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analysed? 7. Were the outcomes of participants included in any comparisons measured in the same way? 8. Were outcomes measured in a reliable way? 9. Was appropriate statistical analysis used?