

# Multi-agency Audit on Pre-Birth Assessments in Kirklees

## 1. Introduction

### Multi-Agency Audits in Kirklees

- 1.1. *Working Together to Safeguard Children* (2010) provides for Local Safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.
- 1.2. The Kirklees Safeguarding Children Board (KSCB) recognises that partner agencies undertake their own audits of practice and will not duplicate this work. Audits undertaken on behalf of the Board focus on multi-agency and multidisciplinary practice, in line with the Principles of Audit provided at Annex A.
- 1.3. This is the first multi-agency audit that the Board has undertaken, and lessons from undertaking this audit will inform future audits. Feedback on the process is provided in Section 7: Lessons about the Audit Process.

### Pre-birth Assessments in Kirklees

- 1.4. Pre-birth assessments have been featured in a number of serious case reviews (SCRs) in Kirklees due to issues with professional understanding of risk as it relates to unborn children; the timeliness and quality of referrals; sharing of information; multi-agency assessment of risk; and plans for further work that include clear timescales.
- 1.5. Key agencies have made improvements to pre-birth assessment processes. The Evaluation and Effectiveness Workstream has undertaken an audit to consider how these improvements have been sustained over time and led to improved outcomes for children.

## 2. The Audit Group

- 2.1. The KSCB invited representatives from the Duty and Assessment Service, midwifery services in both hospital trusts, named nurses for NHS Kirklees and the Child Protection and Review Unit to participate in the audit group. Representatives were:

- Safeguarding Children Manager, KSCB(Chair);
- Manager, Child Protection and Review Unit, Commissioning, ChYPS;
- Named Midwife, Calderdale and Huddersfield NHS Foundation Trust;
- Named Midwife, The Mid Yorkshire Hospitals NHS Trust;
- Named Nurse, NHS Kirklees;
- Team Manager, Duty and Assessment Service, Family Support and Child Protection, Kirklees Children and Young People's Service (ChYPS); and
- Safeguarding Coordinator, KSCB.

### **3. Scope of Audit**

- 3.1. The audit considered if improvements to the processes for undertaking and contributing to pre-birth assessments have been sustained over time led to improved outcomes for children.
- 3.2. The audit group agreed that this would be assessed by considering:
- when the referral was made in relation to the due date and whether this was appropriate;
  - the quality of the information in the referral;
  - the appropriateness and timeliness of the response from the Duty and Assessment Service;
  - assessment planning and communication between agencies (i.e. approaching relevant professionals as part of the assessment process; providing quality information for the purposes of the assessment);
  - the quality of multi-agency risk assessment and decision making;
  - the quality of plans and agreement for further work (if applicable); and
  - the appropriateness of subsequent outcomes.
- 3.3. It was agreed that compliance with internal agency procedures is the responsibility of individual agencies and would not be a focus of this audit. Any identified failures to comply with internal agency procedures were to be followed up by the nominated agency representative on the audit group.

#### **Selection of Cases for Audit**

- 3.4. The Duty and Assessment Service was asked to provide a list of all pre-birth assessments undertaken over a six-month period in 2010. From this list, the audit group selected a third of cases to be considered for the purposes of audit. Selection of cases of cases was as random as possible, whilst ensuring an even split of cases from each hospital trust.

#### **Terms of Reference for the Audit**

- 3.5. The group established and agreed terms of reference and the principles of audit at its first meeting. It was recognised that these documents may need to be re-visited as the audit progressed. The full terms of reference are provided as Annexe B.

#### **Process for Undertaking the Audit**

- 3.6. Agency representatives brought relevant case files to a meeting and, as a group, each was considered against the criteria identified in the scope above (i.e. quality and timeliness of referral; appropriateness of response; assessment planning and communication between agencies; the quality of multi-agency risk assessment and decision making; the quality of plans and agreement for further work, if applicable; and the appropriateness of subsequent outcomes).

### **4. Key Findings**

- 4.1. From the sample of cases considered in the audit, improvements to the processes for undertaking and contributing to pre-birth assessments have led to improved outcomes for children.

4.2. The audit group agreed that they were considering a small sample of cases and it may be difficult to make generalisations about all pre-birth assessments from this sample. This learning point would be picked up in future audits.

4.3. Further details about the specific findings of the audit are provided below.

#### **Timeliness of the Referral**

4.4. The audit group discussed the difficulties in determining an appropriate timeframe for making referrals to Children's Social Care. As a general rule, the named midwives agreed that they would normally advise midwives to make a referral following the second scan at 20-24 weeks. However, this would depend entirely on the circumstances leading to the referral and when concerns are identified (i.e. midwives may refer earlier if the parents have previously had children removed; or later if parents presented late or concerns were only identified following a specific incident).

4.5. Of the cases considered for purposes of the audit, referrals were made between 11 weeks (concerns clearly identified at the time of booking) and 34 ½ weeks (concerns were not identified until this time).

4.6. In all cases, the timeliness of the referral was considered appropriate.

#### **Quality of the Information in the Referral**

4.7. The quality of referrals in these cases was variable. The majority of referrals were considered to be good or excellent; few were considered to be weak or poor.

4.8. Referrals that were considered to be good or excellent were very clear about the concerns of referring professionals and why they were making the referral; contained relevant background information about parents, living arrangements and home conditions; were clear and easy to read; and provided contact details of other professionals involved with the family.

4.9. Referrals that were considered to be weak or poor either:

- provided a lot of information but it was difficult to make sense of the concerns or why the referral was being made; or
- contained isolated pieces of information that were innocuous on their own, but with more context would have raised sufficient concerns. For example, previous children of the parents were living with other family members, but it was not clear why.

4.10. There was no clear correlation between poor referrals and the quality of subsequent assessments and decision making.

4.11. The audit group is aware that partner agencies already deliver training, provide support to staff and undertake their own audits to monitor referrals to children's services. As such, the group agreed that feedback should be provided to referrers in these cases by the appropriate agency representative on the audit group.

### **Appropriateness and Timeliness of the Response from Children's Social Care**

- 4.12. The initial response from Children's Social Care was considered to be timely in the majority of cases. Of the cases that were not completed within timescales, the audit group considered the time for completing the assessment to be appropriate given the complexity of the case; or the delay was addressed through management oversight of the case.
- 4.13. The audit group considered that the initial response from Children's Social Care was appropriate in the vast majority of cases, and management oversight addressed any weaknesses in the initial response.
- 4.14. The audit group noted some confusion regarding the difference between a pre-birth assessment and an unborn section 47 inquiry. The group agreed that this is an internal agency process and other agencies simply needed to be aware that an assessment was being undertaken and advised of the outcome. Furthermore, that agencies needed to be proactive in monitoring referrals and their outcome.

### **Assessment Planning and Communication between Agencies**

#### *Assessment Planning*

- 4.15. The audit group considered the quality of the final pre-birth assessment as an indicator of assessment planning.
- 4.16. The audit group considered the majority of assessments to be good, as they provided a good and comprehensive overview of family history and the concerns that led to the assessment, plus a strong analysis of risk. Few assessments were considered to be poor because they either did not provide an adequate assessment of risk or appeared to adult-focussed. It was agreed that this would be fed back to relevant practitioners by the appropriate agency representative on the audit group.
- 4.17. The weaknesses in poor assessments were addressed before they came to the attention of the audit group, either through robust management oversight of the case or through the initial child protection conference.
- 4.18. It was agreed that the audit group's findings in regard to these assessments would be fed back to the relevant practitioners.

#### *Communication between Agencies*

- 4.19. The group noted that communication between agencies during assessments was good or adequate in the vast majority of cases. In those cases that were considered to have good communication, all relevant agencies provided information to inform the assessment process, and the outcome of the assessment was well communicated. Those considered to be adequate had sufficient communication to inform the assessment process, but an ongoing dialogue between agencies may have been appropriate. Poor communication was apparent in cases which appeared to have significant gaps in agency information and the outcome of the assessment was not communicated.
- 4.20. The audit group highlighted the following as good practice:

- providing/seeking regular feedback between the midwife and social worker, particularly if the assessment is taking some time and the due date is approaching; and
- ensuring relevant agencies have a copy of the completed assessment.

### **Quality of Multi-Agency Risk Assessment and Decision Making**

- 4.21. Most cases were subject to initial child protection conference and, of these cases, the vast majority were held within timescales. Attendance at conferences was generally good and included appropriate agency representatives; and assessments were considered to be robust.
- 4.22. In those instances where not all relevant professionals were able to attend the conference or the assessment was not completed in time for the conference, the group agreed that this did not have an adverse affect on the outcome for the child.

### **Quality of Plans and Agreement for Further Work**

- 4.23. Birth plans were in place for half of the cases considered. Those birth plans were considered to be good, with clear information about contact and discharge arrangements and the reasons for this clearly and succinctly explained. The audit group agreed that birth plans should be in place for all cases, recognising the difficulties that can arise in the absence of a clear birth plan.
- 4.24. The audit group recognised that the development of a birth plan when there will be no further action from Children's Social Care is good practice and should be shared.
- 4.25. Child protection plans were developed in four cases. All of these plans were considered to be fit for purpose. One plan was considered to be excellent because it ensured weaknesses in the pre-birth assessment were acknowledged and redressed.

### **Appropriateness of Subsequent Outcomes**

- 4.26. In all cases the outcome of the assessment process, ranging from no further action; to subject to a child protection plan; to subject to care proceedings, was considered to be appropriate and demonstrated sound decision making.
- 4.27. As such, these cases indicate that improvements to the processes for undertaking and contributing to pre-birth assessments have led to improved outcomes for children.

## **5. Conclusions about the Findings**

- 5.1. The majority of the cases considered by this audit group identified no concerns about the effectiveness of multi-agency working in relation to pre-birth assessments. No lessons for improving multi-agency practice were identified.
- 5.2. The audit process did identify lessons resulting from good practice that can be shared with other practitioners (further information in section 7.1 below).
- 5.3. The audit group felt some areas of practice were not as robust as they could have been. However, agencies had already identified these weaknesses and addressed them before the cases were audited. As such, problematic practice did not result in poor outcomes for children because management oversight of cases and decision

making through initial child protection conferences was robust enough to redress any weaknesses at earlier stages of the process.

- 5.4. The audit group agreed that cases considered through the audit indicate that pre-birth assessment processes in Kirklees have sufficient monitoring and safeguards in place to ensure that any weaknesses are addressed and children are kept safe.

## **6. Lessons for Agencies about Pre-birth Assessments**

### **Good Practice Identified Through the Audit**

#### Birth Plans

- 6.1. The audit group were impressed with the quality of birth plans and agreed that they should be provided for every case that has completed a pre-birth assessment. Good birth plans were clear and succinct, with bullet points detailing contact and discharge arrangements and the reasons why such arrangements are in place. These birth plans were succinct, recognising that they would need to be considered in busy delivery suites, yet provided enough evidence to ensure clarity about contact and discharge arrangements.
- 6.2. The group also recognised good practice in providing a birth plan in instances where the pre-birth assessment results in no further action being taken from Children's Social Care. In this case such a plan ensured that practitioners were clear about the outcome of the assessment, and ensured that, on delivery, everyone knew what arrangements were to be made. It was agreed that this should be promoted throughout agencies.

#### *How will this be shared with relevant agencies?*

- 6.3. Agency representatives will promote the use of birth plans in individual practice, encouraging practitioners to develop or actively seek the development of birth plans to ensure that all practitioners are clear about contact arrangements on delivery.

#### Good reasons to make a referral, clear referrals, strong assessments and robust plans

- 6.4. The audit group identified a number of areas of good individual practice within these cases and agreed that this should be fed back to relevant practitioners.
- 6.5. The audit group will consider how good practice from these cases will be promoted more broadly.

### **Improvements**

- 6.6. Although the audit group did identify some weak practice in some cases, this was not considered to be systemic and it was agreed that these issues would be best fed back to individual practitioners by the relevant agency representative.

## **7. Lessons about the Audit Process**

- 7.1. The audit group were really positive about the audit as a process for learning and gaining greater understanding of other agency roles and responsibilities. All agreed to take lessons to back to their agency and ensure that practitioners were aware of both good and problematic practice and the impact this can have on children.

### **Good Practice to be Carried Forward**

7.2. The group agreed that:

- the principles of audit be adopted across all future KSCB audits;
- terms of reference were clear and provided a good structure for the meeting to consider cases, and a similar format should be adopted for each meeting; and
- a note taker should be allocated to each audit.

### **Improvements for Future Audits**

7.3. The audit group agreed that future audits should:

- consider more cases to ensure that lessons from the audit a more representative of all cases;
- encourage agencies to read through each case against the terms of reference and ensure that relevant records were to hand; and
- be mindful of the need to return agency records to the office when setting meeting times.

# Appendix One: Principles for Audit

## Evaluating multi-agency working in Kirklees

### Introduction

*Working Together to Safeguard Children* (2010) provides for Local Safeguarding Children Boards to evaluate multi-agency working through joint audits of case files. Multi-agency audits provide an opportunity to consider the involvement of different agencies, and identify the quality of practice and lessons to be shared in terms of both multi-agency and multidisciplinary practice.

In Kirklees, this work will be of particular relevance to the:

- Evaluation and Effectiveness Workstream, given their responsibility for monitoring member agencies effectiveness in terms of their work to safeguard and promote welfare of children and young people; and achieving consistently high standards in safeguarding through evaluation and promoting continuous improvement; and
- Serious Case Review Workstream – given their responsibility for establishing a means of monitoring and auditing the actions of all agencies against recommendations and intended outcomes.

As such, it is considered appropriate for these workstreams to agree general principles for undertaking audits of case files, and establishing task and finish groups to undertake a specific audit.

### General Principles

The Kirklees Safeguarding Children Board (KSCB):

- recognises that partner agencies undertake their own audits of practice and will focus on multi-agency and multidisciplinary interventions. Any issues identified for a single agency during the course of that audit will be reported back to that agency;
- recognises that managing performance of particular staff members is the sole responsibility of their employing agency and will, wherever possible, ensure that audits focus on systemic issues rather than individual practice;
- will ensure that audits:
  - have a clear focus and clearly defined terms of reference;
  - focus on current practice, considering interventions that have occurred within the last 12 months (maximum). Precise timeframes will be established by terms of reference;
  - consider interventions that are within the remit of Kirklees agencies; and
  - include a focus on the welfare of the child, other children living in the household, timeliness, communication and engagement with families or other significant adults.

## **Establishing an Area of Practice to be considered for Audit**

Audits may be identified through serious case reviews; S11 audit; child death overview process; other workstreams; and/or other areas as identified by the Board. The KSCB Unit will develop a programme of audits, which will be approved by the Evaluation and Effectiveness Workstream.

## **Establishing a Task and Finish Group**

The programme of audit will enable the workstream to consider which agencies should be represented on the task and finish group for each audit. Each group will include at least one officer from the KSCB Unit.

The relevant agency will be asked to nominate a suitable representative to participate in a task and finish group as required. Staff participating in the task and finish groups will need allocated time to attend meetings and undertake work on behalf of the group to ensure that audits are completed within agreed timescales.

## **Establishing a Terms of Reference for the Audit**

The task and finish group will establish a clear terms of reference for the audit. This will include, as a minimum:

- The goal of the audit – what is the group trying to find out about multi-agency working?
- What specific aspect of the intervention will be considered? To include, as a minimum, a focus on the welfare of the child, timeliness, communication and engagement with families.
- Which agencies will be asked to provide information? What information will be required?
- How many cases will be considered?
- Who will be responsible for undertaking which tasks, including collating the final report for the Board?
- What is the timeframe for completing the audit?

## **Undertaking the Audit**

The task and finish group will be required to meet and consider cases as a group.

It is proposed that audits consider a random sample of cases. The task and finish group will need to determine how many cases they wish to consider as part of the audit and which agencies will be approached for information. They can then ask agencies to provide a list of all relevant cases within a particular time period. The group will then need to randomly select the appropriate number of cases from within this list.

It is recognised that this process may identify some cases that require specific attention as a result of good practice or areas for development. The KSCB Unit has an established process for conducting practice reviews, and is currently developing a process for reviewing cases that do not meet the serious case review criteria but may identify lessons for multi-agency working.

This process will be developed in consultation with relevant workstreams and ultimately approved by the Board.

## **Audit Findings**

The findings of the audit will be collated and presented to the Evaluation and Effectiveness Workstream for quality assurance purposes. Quality assured audit reports, which will include recommendations if appropriate, will then be shared with the Board and relevant workstreams.

# **Appendix Two: Terms of Reference for Multi-agency Audit**

## Considering Pre-birth Assessments in Kirklees

### **Introduction**

*Working Together to Safeguard Children* (2010) provides for Local Safeguarding Children Boards to evaluate multi-agency working through joint audits of case files. Multi-agency audits provide an opportunity to consider the involvement of different agencies, and identify the quality of practice and lessons to be shared in terms of both multi-agency and multidisciplinary practice.

The Kirklees Safeguarding Children Board (KSCB)

- recognises that partner agencies undertake their own audits of practice and will focus on multi-agency and multidisciplinary interventions. Any issues identified for a single agency during the course of that audit will be reported back to that agency; and
- recognises that managing performance of particular staff members is the sole responsibility of their employing agency and will, wherever possible, ensure that audits focus on systemic issues rather than individual practice.

### **Reason for Audit**

Pre-birth assessments have been featured in a number of serious case reviews (SCRs) in Kirklees due to issues with professional understanding of risk as it relates to unborn children; the timeliness and quality of referrals; sharing of information; multi-agency assessment of risk; and plans for further work that include clear timescales.

Key agencies have made improvements to pre-birth assessment processes. The Evaluation and Effectiveness Workstream has therefore requested an audit to consider how these improvements have been sustained over time and led to improved outcomes for children.

### **Purpose of Audit**

The purpose of this audit is to consider the effectiveness of multi-agency working in relation to pre-birth assessments and to ensure that any lessons for improving practice are identified and acted on.

Compliance with internal agency procedures is the responsibility of individual agencies and will not be the focus of this audit. Any identified failures to comply with internal agency procedures will be reported back to the appropriate agency.

### **Representatives on Task and Finish Group**

This group will require representatives from:

- Unit/Team Manager, Duty and Assessment Service, Family Support and Child Protection, Kirklees Children and Young People’s Service;
- Named Midwife, Calderdale and Huddersfield NHS Foundation Trust and/or the Mid Yorkshire Hospitals NHS Trust;
- Named Nurse, NHS Kirklees;
- Independent Reviewing Officer/Manager, Child Protection and Review Unit, Commissioning, Kirklees Children and Young People’s Service; and
- Safeguarding Coordinator from the Kirklees Safeguarding Children Board Unit.

Relevant agencies will be asked to nominate a suitable representative to participate. Staff participating in this task and finish group will need allocated time to attend meetings and undertake work on behalf of the group to ensure that audits are completed within agreed timescales.

This group will be chaired by the safeguarding children manager.

## **Scope of Audit**

This audit will consider how professionals maintained a focus on the welfare of the child or children in the household, engaged with families and communicated appropriately with other professionals. The audit will examine the appropriateness, timeliness and quality of the:

- referral to the Duty and Assessment Service ;
- information gathered/provided as part of the assessment process;
- multi-agency consideration of risk; and, if appropriate the
- initial child protection conference.

## **Cases to be considered**

The Duty and Assessment Service will be asked to provide a list of all cases referred to the Duty and Assessment Service for the purposes of pre-birth assessment over a six month period. From this list, the audit group will randomly select an appropriate number of cases to be considered.

## **Undertaking the Audit**

The task and finish group will be required to meet and consider cases as a group. Agency representatives will be required to bring all relevant files to this meeting to facilitate discussion. The chair will ask each representative to provide an overview of their agencies information as it relates to the:

- referral to the Duty and Assessment Service ;
- information gathered/provided as part of the assessment process;
- multi-agency consideration of risk; and, if appropriate the

- initial child protection conference.

From this information, attendees will be required to consider any lessons for multi-agency working and how they might best be embedded across agencies. Any issues identified for a single agency will be noted by the safeguarding coordinator and reported back to that agency.

It is recognised that this process may identify some cases that require specific attention as a result of good practice or areas for development. The KSCB Unit has an established process for conducting practice reviews, and is currently developing a process for reviewing cases that do not meet the serious case review criteria but may identify lessons for multi-agency working. This process will be developed in consultation with relevant workstreams and ultimately approved by the Board.

### **Task List**

1. Audit panel members to confirm their participation in audit and advise their availability to attend meetings.
2. 1<sup>st</sup> meeting to confirm terms of reference and cases to be considered.
3. 2<sup>nd</sup> meeting to consider agency records against established terms of reference and identify good practice and/or areas for improvement.
4. Safeguarding coordinator to draft report of findings and circulate to audit group
5. Panel to consider and make comments against draft report (safeguarding coordinator to incorporate comments and circulate to Evaluation and Effectiveness Workstream).
6. Written findings presented to Evaluation and Effectiveness Workstream.

### **Audit Findings**

The findings of the audit will be collated and presented to the Evaluation and Effectiveness Workstream for quality assurance purposes. Quality assured audit reports, which will include recommendations if appropriate, will then be shared with the Serious Case Review Workstream and the Board.