Leicester LSCB Multi-agency Audit: Pre-birth 2016-2017

Summary

This summary (briefing) is aimed at managers and practitioner working with children and families in Leicester. Information about Pre-birth and Key findings/recommendations from the audit is presented. Please share this summary (briefing) with colleagues.

Background

- Working Together to Safeguard Children (2015) requires Local safeguarding Children Boards to evaluate multi-agency working through joint audits of case files
- A multi-agency LSCB audit on Pre-birth was conducted in December 2016 to January 2017, as recommended by local Serious Case Reviews. The audit involved checking compliance and seeking assurance to the application of the LLR LSCB multi-agency safeguarding procedures; partner agency identification and response to cases where pre-birth (safeguarding an unborn child) is a theme; identifying learning to improve practice in safeguarding unborn children.
- The audit report will be presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

What is pre-birth?

Young babies are particularly vulnerable to abuse, and early identification/assessment and support work carried out during the antenatal period can help minimise potential risk of harm to the unborn child. Timely assessments should lead to robust planning for the safety and wellbeing of the baby.

All professionals/practitioners have a role in identifying and assessing families in need of additional support or where there are safeguarding concerns. In most situations there will be no safeguarding concerns during the mother's pregnancy, however, in some cases a co-ordinated response from agencies will be required to ensure that appropriate support is in place during pregnancy to safeguard the child before ad following birth. Practitioners when they become aware of the pregnancy and of any safeguarding concerns in relation to the mother, unborn child or siblings should consider the action they need to take to consider their safety.

Practitioners should consider whether the baby following birth will be safe in the care of the adults who will be significant in the baby's daily care always to include mother, father or partners. Consideration should be given to whether they will be able to care for the child throughout the child's childhood

Methodology

The audit process, sample and selection of cases, scope and audit tool was discussed and agreed by the LSCB audit group, which has representatives from the following agencies:

- Clinical Commissioning Group
- Leicestershire Police
- Children Social Care, Safeguarding Unit, Leicester City Council
- Leicestershire Partnership Trust (LPT)
- University Hospitals of Leicester (UHL)
- LSCB office

The audit included accuracy of case details, referrals and response, and identification of DV. Underpinning this was the consideration for the unborn child and compliance to procedures.

Ten cases were selected for auditing from a list of cases provided by Children's Social Care. Not all cases were known to the agencies conducting the audits. The audit was completed by 17th January 2017.

The audit was completed by: Leicester City Council's – Safeguarding Unit, Leicestershire Police, Leicestershire Partnership Trust (LPT), University Hospitals of Leicester (UHL) and Clinical Commissioning Group (CCG). Ten cases were audited by Leicester Police, but not all questions were responded in all cases as there was no information on the child/family in relation to some cases. Eight cases were audited by the CCG as 2 practices did not complete the audit.

Further Information

- LSCB Website: http://www.lcitylscb.org/
- LLR LSCB Multi-agency safeguarding procedures: http://llrscb.proceduresonline.com/chapters/contents.html

Key Findings/conclusion

- There was swift intervention and response by health practitioners leading to reduction in risk, information sharing between partner agencies where required and on-going intervention with the mother and mental health services by a GP.
- Similar to previous audits the pre-birth audit found that practice and compliance to procedures was variable. Recording of demographic details, date of births, spelling of names and surnames remains an issue.
- Following the audit the midwifery service's process for notifying the GPs and Health Visiting Service of a women's pregnancy and of safeguarding concerns, was amended to clarify to GPs and health visitors whether a referral has been made to Children Social Care by the midwifery service and to document the safeguarding concerns identified.
- There was communication between key partners, however, Children Social Care need to ensure that key partners such as health visitors are informed of cases where safeguarding concerns are identified, so that they can be involved in planning for the safeguarding of the child and mother at the out-set.
- In majority of the cases the referrals made to Children Social Care were timely, provided key information and met the threshold, although there is need for the threshold to be applied appropriately when 'stepping up or down' a case.
- If feedback to the referrers from Children Social Care included the rationale for the decision made, it would allow practitioners to make an informed decision of whether to escalate or not, although partners need to ensure that they escalate decisions that they are concerned about.
- Assessments within Children Social Care were timely, but more robust decision making is required and both the assessment and planning process needs to ensure that key professionals are invited to and contribute to multi-agency meetings. Minutes of meetings were not shared with partners consistently and there were inaccuracies in some social care recordings and minutes, and plans were not robust and SMART. However, partners have responsibility to contribute to multi-agency assessments, meetings and plans and to ensure that these are robust and meet intended outcomes.
- A focus on seeking the fathers' engagement in safeguarding intervention is required to ensure their involvement in the planning for the safety of the unborn child and mother.
- The audit group was not sufficiently assured that all the cases audited had been appropriately assessed and had appropriate plans put in place, for example, three cases were to be re-visited by Children Social Care.

Recommendations

1. Partner agencies to ensure that the threshold for accessing services for children and families in Leicester, Leicester and Rutland, is understood and applied appropriately by practitioners within their service/agency.
2. Partner agencies to ensure that case recordings contain accurate details.
3. Children Social Care to ensure that health visitors are informed of cases where safeguarding concerns are identified for the unborn baby/mother so that they can be involved at the outset and are aware of the history of intervention and concern following the child's birth.
4. Partner agencies to ensure that practitioners within their agency are aware of and use the escalation process where appropriate.
5. Partner agencies to seek fathers' engagement in pre-birth safeguarding planning for the unborn child and mother.
6. Assessment and planning processes within Children Social Care to ensure that assessment outcomes are appropriate to the risk identified and plans are SMART.
7. Children Social Care to ensure that key partners are invited to multi-agency meetings, including health visitors and accurate minutes are shared with key partners.